VAN NATTA'S WORKERS' COMPENSATION REPORTER

VOLUME 40

(Pages 325-764)

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.

APRIL-JUNE 1988

Edited & published by:

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

CONTENTS

Workers' Compensation Board Decisions	325
Court Decisions	613
Subject Index	716
Citations to Court Cases	733
References to Van Natta Cases	740
ORS Citations	743
Administrative Rule Citations	748
Larson Citations	750
Oregon Evidence Code Citations	750
Oregon Rules of Civil Procedure Citations	750
Memorandum Opinions	751
Own Motion Jurisdiction	753
Claimant Index	757

CITE AS

40 Van Natta ____ (1988)

DANIEL J. BERGMANN, Claimant
Malagon & Moore, Claimant's Attorneys
SAIF Corp Legal, Defense Attorney

Own Motion 87-0737M
April 1, 1988
Consent to Issuance of Order Designating a Paying Agent (ORS 656.307)

The Compliance Division has notified the Board that it is prepared to issue an order designating a paying agent under ORS 656.307 and OAR 436-60-180. Each of the employers/insurers have provided their written acknowledgment that the only issue is responsibility for claimant's otherwise compensable claim. Claimant's aggravation rights under his claim with SAIF Corporation have expired. Thus, that claim is subject to ORS 656.278.

Pursuant to OAR 438-12-032(3), the Board shall notify the Compliance Division that it consents to the order designating a paying agent, if it finds that the claimant would be entitled to own motion relief if the own motion insurer is the party responsible for payment of compensation. The Board may exercise its own motion jurisdiction if there is a worsening of a compensable injury that requires either inpatient or outpatient surgery or other treatment requiring hospitalization. ORS 656.278(1)(a). In such cases, the Board may authorize the payment of temporary disability compensation from the time the worker is actually hospitalized or undergoes outpatient surgery until the worker's condition becomes medically stationary, as determined by the Board. id.

The record establishes that there has been a worsening of claimant's compensable injury requiring either inpatient or outpatient surgery or other treatment requiring hospitalization. Inasmuch as claimant would be entitled to own motion relief if the own motion insurer is found responsible for claimant's current condition, the Board consents to the order designating a paying agent. Furthermore, for the purposes of ORS 656.625 and OAR 436, Division 45, this consent constitutes an order reopening a claim under ORS 656.278 and the Board's rules if the designated paying agent is an own motion insurer. See OAR 438-12-032(3).

IT IS SO ORDERED.

JAN CONNELL, Claimant
David Hollander, Claimant's Attorney
SAIF Corp Legal, Defense Attorney

Own Motion 88-0078M
April 1, 1988
Own Motion Order

The SAIF Corporation has submitted to the Board claimant's claim for a worsening of her October 9, 1979 compensable cervical condition. Claimant's aggravation rights have expired. SAIF recommends that the claim be reopened for payment of temporary total disability compensation from the date of the surgery.

Pursuant to ORS 656.278(1)(a), we may exercise our "Own Motion" authority when we find that there is a worsening of a compensable injury that requires either inpatient or outpatient surgery or other treatment requiring hospitalization. In such cases, we are authorized to award temporary disability compensation commencing from the time the worker is actually hospitalized or undergoes outpatient surgery. ORS 656.278(1)(a).

Following our review of this record, we are persuaded

that claimant is entitled to compensation commencing from the date she undergoes surgery or other treatment requiring hospitalization. See ORS 656.278(1)(a). Accordingly, claimant's claim is reopened with temporary total disability compensation to commence from the date of her hospitalization and to continue until she returns to her regular work at her regular wage or is medically stationary, whichever is earlier. See OAR 438-12-052(2). As a reasonable attorney's fee, claimant's attorney is awarded 25 percent of the increased compensation created by this order, not to exceed $300. Reimbursement from the Reopened Claims Reserve is authorized to the extent allowed under ORS 656.625 and OAR 436, Division 45. When appropriate, the claim shall be closed by SAIF pursuant to OAR 438-12-055.

IT IS SO ORDERED.

JEANETTE M. ALESHIRE, Claimant
Roger D. Wallingford, Claimant's Attorney
Rankin, VavRosky, et al., Defense Attorneys

WCB 86-11759
April 5, 1988
Order on Reconsideration

The self-insured employer requests reconsideration of the Board's February 25, 1988 order, as amended March 16, 1988, which awarded claimant's attorney an assessed fee of $150 for services on Board review. The employer contends that no fee should be awarded because claimant failed to timely file his respondent's brief. The employer argues, in the alternative, that a reduced fee is appropriate.

The request for reconsideration is granted and our prior order, as amended, is withdrawn. Upon further review, the Board adheres to and republishes its former order, as amended, effective this date. See Myron W. Rencehausen, 39 Van Natta 56 (1987).

IT IS SO ORDERED.

GLEN L. EDENS, Claimant
Francesconi & Associates, Claimant's Attorneys
Rick Barber (SAIF), Defense Attorney
Schwabe, et al., Defense Attorneys

WCB 84-07667, 82-09893, 82-09894 & 84-10890
April 5, 1988
Order of Partial Dismissal and Interim Order of Remand

The SAIF Corporation requests review of those portions of Referee Baker's order that: (1) set aside its partial denial relating to claimant's low back and sacroiliac conditions; (2) set aside its partial denial relating to claimant's psychological condition; and (3) ordered it to pay claimant's attorney an attorney fee of $3,000. Claimant cross-requests review of that portion of the order that upheld SAIF's partial denial relating to bilateral hearing loss. The issues are compensability, responsibility and attorney fees.

The parties have submitted for our approval a proposed "Stipulation and Order for Partial Disputed Claim Settlement of Partial Denial." The agreement is designed to resolve all issues raised or raisable in this matter, "excepting the responsibility for claimant's low back symptoms and disability, including his right-sided sacroiliac symptoms and increased symptoms in the area of his preexisting spondylolisthesis." In addition, the parties have agreed to resolve the issues currently pending before the Hearings Division in WCB Case No. 87-10442. That portion of the agreement which pertains to the Hearings Division has received Referee approval.

We have approved the agreement, thereby fully and finally resolving the issues raised or raisable herein, with the exception of the aforementioned responsibility issue and attorney fees, if any, resulting from the Board's eventual order. Accordingly, save for these exceptions, the requests for Board review are dismissed.

We turn to the remaining issues. The record in this case was left open after the hearing for the deposition of Dr. Newby, a neurosurgeon. The parties refer to this deposition in their briefs. The record submitted to the Board does not contain a copy of Dr. Newby's deposition. The Board finds, therefore, that this case has been "improperly, incompletely or otherwise insufficiently developed" and remands the case to the Referee for correction of this deficiency in the record. ORS 656.295; Michael J. Bruno, 38 Van Natta 1019 (1986).

The Board retains jurisdiction over this matter. After inclusion of this deposition into the record, the Referee is directed to issue an Order on Remand discussing the effect, if any, the deposition has had upon his prior order. Upon receipt of the Referee's Order on Remand, the Board shall take this matter under advisement.

IT IS SO ORDERED.

JOHN D. HARTLEY, Claimant
Hayner, et al., Claimant's Attorneys
Cummins, et al., Defense Attorneys

WCB 86-17365
April 5, 1988
Order on Review

Reviewed by Board Members Crider and Johnson.

The self-insured employer requests review of Referee Garaventa's order that: (1) directed it to pay attorney fees as required by a prior Referee's order; and (2) assessed penalties and attorney fees for its failure to comply with the prior Referee's order. On review, the issues are penalties and attorney fees.

The Board affirms and adopts the order of the Referee.

Inasmuch as penalties and attorney fees are not "compensation" within the meaning of ORS 656.382(2), claimant is not entitled to attorney fees for successfully defending those awards on Board review. See Saxton v. SAIF, 80 Or App 631 (1986), and Dotson v. Bohemia, Inc., 80 Or App 233 (1986).

Finally, after review of the statement of services and the attorney referral letter in this particular case, as submitted by the employer's counsel, and considering the factors set forth in OAR 438-15-010(6), we approve a client-paid fee, not to exceed $195.50.

ORDER

The Referee's order dated May 8, 1987 is affirmed.

The Beneficiaries of
ROCKNE LUCKMAN (Deceased), Claimant — WCB 85-12369 & 86-04809
Martin McKeown, Claimant's Attorney — April 5, 1988
Kate Donnelly (SAIF), Defense Attorney — Order on Reconsideration

The SAIF Corporation has requested reconsideration of our Order on Review dated February 25, 1988, which affirmed the Referee's order finding inter alia, that decedent was a subject employe. On March 16, 1988, after receiving decedent's beneficiary's response, the Board abated its order so that it could further consider the matter.

On reconsideration, the Board adheres to and republishes its order with the following amendments.

The Board affirms and adopts that portion of the Referee's order pertaining to the issue of the compensability of claimant's March 1985 eye injury claim.

After our order issued, claimant's counsel submitted a statement of services pursuant to OAR 438-15-010(5). In our order, we awarded claimant's counsel a reasonable assessed fee of $500 for services on Board review. After review of the statement of services and attorney retainer agreement previously submitted by claimant's counsel and considering the factors set forth in OAR 438-15-010(6), we conclude that our prior award was reasonable. Accordingly, we continue to approve a reasonable assessed fee of $500 for claimant's attorney.

IT IS SO ORDERED.

JOHN E. MAYFIELD, Claimant — Own Motion 88-0096M
W. Daniel Bates, Claimant's Attorney — April 5, 1988
SAIF Corp Legal, Defense Attorney — Own Motion Order

SAIF Corporation has submitted to the Board claimant's claim for an alleged worsening of his February 9, 1979 industrial injury. Claimant's aggravation rights have expired. SAIF opposes claim reopening for the payment of temporary total disability compensation as claimant has not been gainfully employed since his 1979 injury. Claimant argues that his unemployed status is the result of an 80 percent disability due to his injury and the fact that he was in jail for several years for a charge which was later allegedly reversed.

Pursuant to ORS 656.278(1)(a), we may exercise our own motion authority when we find that there is a worsening of a compensable injury that requires either inpatient or outpatient surgery or other treatment requiring hospitalization. Our review of the record reveals that claimant did undergo surgery on February 10, 1988. However, our evidence also indicates that, with the exception of a brief period of employment in 1982, claimant has not performed gainful employment since 1979. Claimant's contentions above have been considered. However, claimant has not engaged in furnishing services for remuneration for several years and cannot be considered a worker for the purposes of receiving temporary total disability compensation. Cutright v. Weyerhaeuser Company, 299 Or 290 (1985), and Karr v. SAIF, 79 Or App 250 (1986). The request for own motion relief must be denied.

IT IS SO ORDERED.

STEVE D. McCOY, Claimant
SAIF Corp Legal, Defense Attorney

Own Motion 88-0125M
April 5, 1988
Own Motion Order

The SAIF Corporation has submitted to the Board claimant's claim for a worsening of his July 1, 1981 compensable low back injury. Claimant's aggravation rights have expired. SAIF recommends that the claim be reopened for payment of temporary total disability compensation from the date of the surgery.

Pursuant to ORS 656.278(1)(a), we may exercise our "Own Motion" authority when we find that there is a worsening of a compensable injury that requires either inpatient or outpatient surgery or other treatment requiring hospitalization. In such cases, we are authorized to award temporary disability compensation commencing from the time the worker is actually hospitalized or undergoes outpatient surgery. ORS 656.278(1)(a).

Following our review of this record, we are persuaded that claimant is entitled to compensation commencing from the date he undergoes surgery or other treatment requiring hospitalization. See ORS 656.278(1)(a). Accordingly, claimant's claim is reopened with temporary total disability compensation to commence from the date of his hospitalization and to continue until he returns to his regular work at his regular wage or is medically stationary, whichever is earlier. See OAR 438-12-052(2). Reimbursement from the Reopened Claims Reserve is authorized to the extent allowed under ORS 656.625 and OAR 436, Division 45. When appropriate, the claim shall be closed by SAIF pursuant to OAR 438-12-055.

IT IS SO ORDERED.

JAMES L. PAYNE, Claimant
Malagon & Moore, Claimant's Attorneys
SAIF Corp Legal, Defense Attorney

WCB 86-11360
April 5, 1988
Order on Review

Reviewed by Board Members Johnson and Crider.

Claimant requests review of Referee Michael Johnson's order that found claimant's neck injury claim had not been closed prematurely. On review, claimant contends that his claim was closed prematurely.

ISSUE

Whether claimant's claim was prematurely closed by Determination Order of October 24, 1985.

FINDINGS

Claimant compensably injured his neck and left arm on September 11, 1978.

Claimant sought medical attention for his disabling condition. Dr. Smith, the treating doctor, performed surgery on February 27, 1985. He conducted a followup examination on September 19, 1985. Claimant was deemed medically stationary.

On October 24, 1985, the claim was closed by Determination Order which awarded 35 percent unscheduled

disability for the neck condition and 10 percent scheduled disability for loss of use or function of the left arm. At closure, claimant was deemed medically stationary on September 19, 1985.

Claimant returned to regular work during January 1986, as a faller and bucker, which brought on pain symptoms.

Claimant was reexamined by Dr. Smith on February 27, 1986. X-rays of the cervical spine revealed a modest motion at C5-6. Claimant was determined to have a pseudoarthrosis and an unsuccessful spinal fusion, which had not been diagnosed during the September 19, 1985 evaluation.

Claimant was not medically stationary February 27, 1986.

On April 2, 1986, surgery was performed to correct claimant's cervical spine, after authorization by SAIF Corporation.

On May 8, 1986, the Board issued an own motion order reopening the claim with temporary disability benefits commencing April 2, 1986, the date of surgery.

The claim was again closed by Determination Order of July 31, 1986. Claimant received no additional award of compensation for permanent partial disability, scheduled or unscheduled.

CONCLUSIONS

The Board agrees with claimant's contention that his claim was closed prematurely. Accordingly, the decision of the Referee is reversed.

The Referee relied upon Alvarez v. GAB Business Services, 72 Or App 524 (1985), and Maarefi v. SAIF, 69 Or App 527 (1984), stating that the reasonableness of the medical expectations at the time of closure must be judged by the evidence available at that time, not by subsequent development of the case. Although believing claimant was never "medically-medically stationary," the Referee felt bound by Alvarez and Maarefi, supra. Therefore, the Referee declined to find that the claim had been closed prematurely. We disagree.

"Medically stationary means that no further material improvement would reasonably be expected from medical treatment, or the passage of time." ORS 656.005(17). After the Referee's order issued, the Court of Appeals issued its opinion in Schuening v. J.R. Simplot & Co., 84 Or App 622, rev den 303 Or 590 (1987). The court reiterated that it is claimant's condition at the time of closure without respect to subsequent changes in his condition that is decisive of whether a claim has been prematurely closed. Id. at 625. However, the court held that evidence that was not available at the time of closure may be considered to conclude that a claim has been closed prematurely.

Following our de novo review of the medical and lay evidence, including evidence that became available after claim closure, we are not persuaded that claimant's condition changed subsequent to Dr. Smith's September 1985 evaluation. Instead, we are persuaded by Dr. Smith, claimant's treating surgeon, and the February 1986 x-rays, that the fusion had never stablized.

Inasmuch as we find that claimant's spine had not properly fused at the time of claim closure, we conclude that claimant was not medically stationary. Therefore, the claim was prematurely closed under ORS 656.268.

ORDER

The Referee's Order on Reconsideration dated May 4, 1987 is reversed. The October 24, 1985 and July 31, 1986 Determination Orders are set aside, and the claim is remanded to the SAIF Corporation for further processing according to law. As a reasonable approved attorney fee, claimant's attorney is awarded 25 percent of the increased compensation created by this order, not to exceed $3,800.

JOSEPH SEXTON, Claimant
Quintin B. Estell, Claimant's Attorney

Own Motion 87-0560M
April 5, 1988
Own Motion Determination

The Board issued its Own Motion Order in the above-entitled matter on December 23, 1987, reopening claimant's claim for a worsened condition related to his industrial injury of January 22, 1982. Pursuant to our order, the insurer was directed to pay temporary total disability compensation commencing July 14, 1987 and continuing until closure according to ORS 656.278. Claimant's attorney was also awarded 25 percent of the additional compensation granted by our order, not to exceed $350.

The claim has now been submitted for closure. Claimant is hereby granted temporary total disability from July 14, 1987 through September 20, 1987, less time worked. Deduction of overpaid temporary disability from unpaid permanent disability is approved.

Finally, claimant contends that the insurer has failed to pay the attorney fee as directed by our prior order. The insurer acknowledges that the fee has not been paid to claimant's attorney. However, it explains that the entire amount of temporary disability compensation was erroneously paid to claimant, without forwarding a portion of the compensation to his attorney. Once it discovered its error, the insurer states that it immediately advised claimant's attorney and suggested that claimant provide the attorney fee out of the "overpaid" compensation.

Attorney fees awarded out of claimant's compensation retain their identity as "compensation." David Martin, 39 Van Natta 447 (1987); Candy J. Hess, 37 Van Natta 12 (1985); Robert G. Perkins, 36 Van Natta 1050, 1051 (1984). Failure to timely pay an attorney fee award payable from claimant's compensation is improper and can result in the assessment of a penalty and an additional attorney fee. David Martin, supra; Candy J. Hess, supra.

Following our review of this matter, we conclude that the insurer has unreasonably failed and unreasonably refused to pay claimant's attorney fee as directed by our prior order. Although we are persuaded that the insurer's error was unintentional, the fact remains that it failed to comply with our prior order. Furthermore, despite the discovery of its error, the insurer continues to refuse to provide the attorney fee as previously directed. Under these circumstances, a penalty and accompanying attorney fee will be assessed.

Accordingly, the insurer is directed to pay claimant's attorney the fee awarded by our prior order. As a penalty for its unreasonable conduct, the insurer shall pay to claimant a further sum, equal to 10 percent of the aforementioned attorney fee award. Finally, claimant's attorney is awarded an additional $25 for this penalty issue.

IT IS SO ORDERED.

PATRICK THOMISON, Claimant
SAIF Corp Legal, Defense Attorney

Own Motion 88-0166M
April 5, 1988
Own Motion Order

The SAIF Corporation has submitted to the Board claimant's claim for a worsening of his August 18, 1982 compensable injury. Claimant's aggravation rights have expired. SAIF does not oppose the request for reopening and suggests that the payment of temporary total disability compensation begin the date of his left knee surgery.

Pursuant to ORS 656.278(1)(a), we may exercise our "Own Motion" authority when we find that there is a worsening of a compensable injury that requires either inpatient or outpatient surgery or other treatment requiring hospitalization. In such cases, we are authorized to award temporary disability compensation commencing from the time the worker is actually hospitalized or undergoes outpatient surgery. ORS 656.278(1)(a).

Following our review of this record, we are persuaded that claimant is entitled to compensation commencing from the date he undergoes surgery or other treatment requiring hospitalization. See ORS 656.278(1)(a). Accordingly, claimant's claim is reopened with temporary total disability compensation to commence from the date of his hospitalization or surgery, whichever occurs first, and to continue until he returns to his regular work at his regular wage or is medically stationary, whichever is earlier. See OAR 438-12-052(2). Reimbursement from the Reopened Claims Reserve is authorized to the extent allowed under ORS 656.625 and OAR 436, Division 45. When appropriate, the claim shall be closed by SAIF pursuant to OAR 438-12-055.

IT IS SO ORDERED.

MICHAEL J. WHITNEY, Claimant
Parks & Ratcliff, Claimant's Attorneys
Cowling & Heysell, Defense Attorneys

WCB 86-08779
April 5, 1988
Amended Order on Review

Reviewed by Board Members Johnson and Crider.

The insurer's counsel seeks Board authorization of a client-paid fee for services rendered on review which culminated in our March 24, 1988 Order on Review.

After review of the statement of services and attorney retainer agreement submitted by the insurer's counsel and considering the factors set forth in OAR 438-15-010(6), we approve a client-paid fee, not to exceed $480.

Accordingly, our March 24,1988 order is abated and withdrawn. As amended herein, we adhere to and republish our

March 24, 1988 order in its entirety. The parties' rights of appeal shall run from the date of this order.

IT IS SO ORDERED.

GRANT T. WINDOM, Claimant
SAIF Corp Legal, Defense Attorney

Own Motion 88-0089M
April 5, 1988
Own Motion Order

The SAIF Corporation has submitted to the Board claimant's claim for an alleged worsening of his February 26, 1978 low back injury. Claimant's aggravation rights have expired. SAIF does not oppose the request for reopening and suggests that the payment of temporary total disability compensation begin the date of claimant's low back surgery.

Pursuant to ORS 656.278(1)(a), we may exercise our "Own Motion" authority when we find that there is a worsening of a compensable injury that requires either inpatient or outpatient surgery or other treatment requiring hospitalization. In such cases, we are authorized to award temporary disability compensation commencing from the time the worker is actually hospitalized or undergoes outpatient surgery. ORS 656.278(1)(a).

Following our review of this record, we are persuaded that claimant is entitled to compensation commencing from the date he undergoes surgery or other treatment requiring hospitalization. See ORS 656.278(1)(a). Accordingly, claimant's claim is reopened with temporary total disability compensation to commence from January 14, 1988, the date of his hospitalization and surgery, to continue until he returns to his regular work at his regular wage or is medically stationary, whichever is earlier. See OAR 438-12-052(2). Reimbursement from the Reopened Claims Reserve is authorized to the extent allowed under ORS 656.625 and OAR 436, Division 45. When appropriate, the claim shall be closed by SAIF pursuant to OAR 438-12-055.

IT IS SO ORDERED.

EVELYN G. HAINES, Claimant
Kilpatricks & Pope, Claimant's Attorneys
David Aamodt (SAIF), Defense Attorney

WCB 87-16280
April 7, 1988
Interim Order of Remand

The SAIF Corporation has requested Board review of Referee Hayduke's January 27, 1988 order that set aside its denial of claimant's claim for a myocardial infarction. The hearing concerning this matter was convened on December 9, 1987 in Canyon City, Oregon. The hearing was electronically recorded.

Following SAIF's request for review, a transcription of the proceedings was requested. See ORS 656.295(3). The Board has been advised that the transcription tape of the hearing has been misplaced. Consequently, no transcript of the January 27, 1987 proceedings can be prepared for purposes of Board review.

Should we determine that a case has been improperly, incompletely, or otherwise insufficiently developed, we may remand to the Referee for further evidence taking, correction, or other necessary action. ORS 656.295(5). Considering the aforementioned circumstances, we conclude that remand is an appropriate action.

Accordingly, this matter is remanded to Referee Hayduke with instructions to reconvene a hearing. At this new hearing, the parties shall be entitled to present testimonial evidence concerning the issues that were addressed at the prior hearing.

We retain jurisdiction over this matter. Upon completion of the hearing, Referee Hayduke shall obtain and certify a copy of the transcript of this proceeding to the Board. This transcript should be forwarded to the Board within 30 days of the hearing. In addition, Referee Hayduke shall provide an interim order on remand, discussing the effect, if any, the additional testimony has had upon his prior order. Once the Board receives the transcript, copies will be presented to the parties and a briefing schedule will be implemented.

IT IS SO ORDERED.

SIDNEY C. HAMAR, Claimant
W.D. Bates, Jr., Claimant's Attorney
Brian Pocock, Defense Attorney

WCB 86-17566
April 8, 1988
Interim Order of Remand

Claimant has requested Board review of Referee Myers' October 12, 1987 order that upheld the self-insured employer's denial of claimant's claim for carpal tunnel syndrome. The hearing concerning this matter was held on October 2, 1987 in Eugene, Oregon. The hearing was electronically recorded.

Following claimant's request for review, a transcription of the proceedings was requested. See ORS 656.295(3). The hearing reporter has advised the Board that the second transcription tape of the hearing is blank. Consequently, only a partial transcript of the October 2, 1987 proceeding presently exists for purposes of Board review. The missing portion of the transcript apparently pertains to the cross-examination and redirect examination of an expert witness, Dr. Nathan.

Should we determine that a case has been improperly, incompletely, or otherwise insufficiently developed, we may remand to the Referee for further evidence taking, correction, or other necessary action. ORS 656.295(5). Considering the aforementioned circumstances, we conclude that remand is an appropriate action.

Accordingly, this matter is remanded to the Referee with instructions to reconvene a hearing. The limited purpose of this hearing is to allow the parties to complete their respective examinations of Dr. Nathan. Thus, claimant shall be permitted to continue with his cross-examination and the employer shall be entitled to conduct redirect examination.

We retain jurisdiction over this matter. Upon completion of the hearing, Referee Myers shall obtain and certify a copy of the transcript of this proceeding to the Board. This transcript should be forwarded to the Board within 30 days of the hearing. In addition, Referee Myers shall provide an interim order on remand, discussing the effect, if any, the additional testimony has had upon his prior order. Once the Board receives the transcript, copies will be presented to the parties and a briefing schedule will be implemented.

IT IS SO ORDERED.

CLAUDE E. HARRIS, Claimant
Roberts, et al., Defense Attorneys

WCB 87-16670
April 8, 1988
Order of Dismissal

Claimant has requested review of Referee Shebley's Order of Dismissal dated January 28, 1988. We have reviewed the request to determine whether we have jurisdiction to consider the matter.

FINDINGS

Claimant's request, dated February 29, 1988 and containing a postmark date of March 2, 1988, was received by the Board on March 3, 1988. The request was neither mailed by registered nor certified mail. In addition, the request did not include an acknowledgment of service or a certificate of personal service by mail upon the employer, its insurer, or its attorney.

CONCLUSIONS

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

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

Here, the 30th day after the Referee's January 28, 1988 order was February 27, 1988, a Saturday. Thus, the last day to timely file a request for Board review was Monday, February 29, 1988. See ORS 174.120. Claimant's February 29, 1988 request for Board review was timely dated. However, the request was neither timely mailed nor filed with the Board. Furthermore, neither the employer nor its representatives were 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 v. King, supra.

We are mindful that claimant has requested review without benefit of legal representation. We further realize that an unrepresented party is not expected to be familiar with administrative and procedural requirements of the Workers' Compensation Law. Yet, we are not free to relax a jurisdictional requirement, particularly in view of Argonaut Insurance Co. v. King, supra. See Alfred F. Puglisi, 39 Van Natta 310 (1987); Julio P. Lopez, 38 Van Natta 862 (1986).

Accordingly, the request for Board review is dismissed.

CHESTER JOHNSON, Claimant
David W. Stauffer, Claimant's Attorney
Roberts, et al., Defense Attorneys

WCB 87-02828
April 8, 1988
Order Denying Motion to Dismiss

The self-insured employer has moved the Board for an order dismissing claimant's request for review on the ground that copies were not timely mailed to the parties. The motion is denied.

The Referee's order issued November 12, 1987. On December 7, 1987, claimant's counsel mailed a request for Board review. The request indicated that a copy had been provided to the claims processor for the employer. The Board received the request on December 8, 1987. The employer's counsel represents that his firm did not receive a copy of claimant's request for review. Furthermore, according to the employer's counsel, the firm's first notice that a request for review had been filed occurred on February 19, 1988, when it received a transcript and briefing schedule.

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

"Party" means a claimant for compensation, the employer of the injured worker at the time of injury and the insurer, if any, of such employer. ORS 656.005(19). Attorneys are not included within the definition of "party." Robert Casperson, 38 Van Natta 420, 421 (1986). In the absence of prejudice to a party, timely service of a request for review on the employer's insurer is sufficient compliance with ORS 656.295(2) to vest jurisdiction in the Board. Nollen v. SAIF, 23 Or App 420, 423 (1975) rev den (1976).

Here, claimant timely filed a request for Board review of the Referee's order. See ORS 656.289(3). Furthermore, included with the request was claimant's counsel's representation that a copy had been provided to the self-insured employer's claims processor. The claims processor does not dispute this representation. The record fails to support the conclusion that the employer was prejudiced by timely service of claimant's request for review on the employer's claims processor. Under these circumstances, we conclude that we have jurisdiction to consider the request for Board review. See ORS 656.295(2); Argonaut Insurance Co. v. King, supra; Nollen v. SAIF, supra.

Accordingly, the employer's motion to dismiss is denied. Inasmuch as claimant's appellant's brief has already been submitted, the employer's respondent's brief shall be due 14 days from the date of this order. Claimant's reply brief, if any, shall be due seven days from the date of mailing of the employer's respondent's brief.

Finally, claimant seeks attorney fees should he prevail against the motion to dismiss. Yet, he has neither cited, nor

have we found, authority which would empower the Board to award an attorney fee prior to a decision on the merits. Should claimant ultimately prevail on his appeal from the Referee's order, the services rendered in response to the employer's motion will be considered in determining a reasonable attorney fee. See Dan W. Hedrick, 38 Van Natta 208, 210 (1986).

IT IS SO ORDERED.

CHARLA J. KELLY, Claimant
Angelo Gomez, Claimant's Attorney
Mark P. Bronstein (SAIF), Defense Attorney

WCB 87-15241
April 8, 1988
Order of Dismissal

Twin Cedars Guest Home, the employer, has requested review of Referee Mulder's February 17, 1988 order. We have reviewed the request to determine whether we have jurisdiction to consider the matter.

FINDINGS

The employer's request, dated March 17, 1988, was received by the Board on March 21, 1988. The request was neither mailed by registered nor certified mail. In addition, the request did not include an acknowledgment of service or a certificate of personal service by mail upon claimant or her attorney.

CONCLUSIONS

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

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

Here, the thirtieth day after the Referee's February 17, 1988 order was March 18, 1988. Thus, claimant's March 17, 1988 request for Board review was timely dated. However, the request was neither mailed by registered nor certified mail. Since the request was actually received by the Board on March 21, 1988, after the date for filing, it is presumed to be untimely until claimant establishes that the mailing was timely. See OAR 438-05-046(1)(b). Furthermore, neither claimant nor her attorney were 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 v. King, supra.

We are mindful that the employer has apparently requested review without benefit of legal representation. We further realize that an unrepresented party is not expected to be familiar with administrative and procedural requirements of the Workers' Compensation Law. Yet, we are not free to relax a jurisdictional requirement, particularly in view of Argonaut Insurance Co. v. King, supra. See Alfred F. Puglisi, 39 Van Natta 310 (1987); Julio P. Lopez, 38 Van Natta 862 (1986).

Accordingly, the request for Board review is dismissed.

FOREST M. LANE, Claimant
David Hittle, Claimant's Attorney
Davis, Bostwick, et al., Defense Attorneys
Rankin, et al., Defense Attorneys
Meyers & Terrall, Defense Attorneys

WCB 84-00603, 85-05722 & 86-03548
April 8, 1988
Interim Order on Remand

Fireman's Fund Insurance Company requests review of those portions of Referee Quillinan's order that: (1) set aside its denial of claimant's medical services claims for a low back and left leg condition; (2) upheld denials of claimant's medical services claims for the same condition issued by EBI Companies and Eldorado Insurance Company; (3) found claimant's chiropractic treatment reasonable and necessary, up to four times per month; (4) assessed a penalty and associated attorney fee for Fireman's Fund's unreasonable failure to timely pay or deny claimant's medical services claims; and (5) awarded claimant's attorney a $1500 insurer-paid fee for prevailing on the medical services issue. Fireman's Fund also contends that the Referee erred in refusing its request to cross-examine the author of a medical report. It requests that the Board either remand the case or not consider the medical report in its review. EBI cross-requests review of that portion of the Referee's order that assessed a penalty and associated attorney fee for its unreasonable failure to deny claimant's medical services claim. On review, the issues are remand, admission of evidence, responsibility, penalties and attorney fees.

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).

Here, claimant requested a hearing concerning denials of responsibility for his current medical treatment issued by three insurers. Fireman's Fund, EBI and Eldorado were the potentially responsible insurers. The remand request concerns a recent medical report from claimant's treating chiropractor, Dr. Wilson.

There are two reports from Dr. Wilson in the present record. In April 1984, Dr. Wilson opined that claimant's current condition was attributable to his initial injury in 1971 when Fireman's Fund was on the risk. Dr. Wilson based that opinion, in part, on the mistaken belief that claimant had sustained no further work injuries. On December 15, 1986, at EBI's request Dr. Wilson issued a supplemental report. He acknowledged that claimant had, in fact, sustained subsequent work injuries after EBI and Eldorado came on the risk. Nevertheless, he did not change his initial opinion that claimant's current problems were the result of the 1971 injury.

EBI provided Fireman's Fund with a copy of the report one business day prior to the December 22, 1986 hearing. EBI then offered the report as evidence at the hearing. Fireman's Fund objected to the admission of the medical report, absent the opportunity to cross-examine Dr. Wilson. The Referee admitted the exhibit under the "seven-day rule" created by then-existing OAR 438-07-005(3). See Susan Vernon, 37 Van Natta 1562 (1985). Fireman's Fund was not provided an opportunity to cross-examine Dr. Wilson.

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, it is possible that cross-examination of Dr. Wilson would have minimal impact on the outcome of this case.

Nevertheless, insurers are generally entitled to cross-examine or take depositions of physicians rendering opinions admitted into evidence. See OAR 438-07-005(5). Moreover, the opportunity to cross-examine Dr. Wilson is particularly important since the report provides evidence concerning the responsibility issue.

Under these circumstances, we conclude that there is a reasonable likelihood that the outcome of this case would be affected by additional information elicited on cross-examination of Dr. Wilson. See Cain v. Wooley Enterprises, 301 Or 650, 654 (1986). Furthermore, we are persuaded that the cross-examination was not obtainable with due diligence at the time of hearing. Accordingly, we find that the record has been "improperly, incompletely or otherwise insufficiently developed." ORS 656.295(5).

We, therefore, remand this case. Fireman's Fund shall be granted an opportunity to cross-examine Dr. Wilson regarding his December 15, 1986 medical report. After reviewing the results of that cross-examination, 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. We retain jurisdiction. Upon receipt of the Referee's order and a copy of Dr. Wilson's cross-examination, be that by report, deposition or transcript, we shall take this matter under advisement.

ORDER

The Referee's order dated January 23, 1987 is vacated. This case is remanded to Referee Quillinan for further action consistent with this order.

The Beneficiaries of
LEON V. LIACOS (Deceased), Claimant
Michael D. Royce, Claimant's Attorney
Jerry Todd (SAIF), Defense Attorney
James Griffin, Ass't. Attorney General

WCB TP-87030
April 8, 1988
Amended Third Party Distribution Order

The Board has been advised that a mathematical error appears in its March 16, 1988 Third Party Distribution Order. After further review, we agree that clarification of our prior order is appropriate. Consequently, our March 16, 1988 order of distribution is withdrawn and replaced by the following order.

INTRODUCTION

The SAIF Corporation, as paying agency, has petitioned the Board for an order distributing the proceeds of a third party settlement. See ORS 656.593(1)(d). Less attorney fees and litigation costs, SAIF contends that its lien attaches to the proceeds of the settlement that are remaining before a probate court's final distribution to the deceased worker's widow and four adult children.

FINDINGS

The deceased worker died as a result of an occupational exposure to toxic chemicals. The deceased was survived by his widow, Mary K. Liacos, (hereafter claimant), and his four adult children. SAIF accepted the claim and paid benefits. Thereafter, claimant, as personal representative for the decedent's estate, commenced a civil action for wrongful death against a third party.

With SAIF's approval, claimant settled the third party action for $120,000. The settlement was also approved by the Probate Court of the Circuit Court for Clackamas County. The court further ordered that claimant's attorney receive $40,000 of the settlement for attorney fees and $8,368.01 for litigation costs. Claimant was directed to deposit the remaining balance of the settlement in a separate interest-bearing account pending final distribution. Claimant's attorney has submitted an affidavit supporting his contention that litigation costs totalled $8,536.38. We consider this affidavit persuasive and find that litigation expenses for the third party action equalled $8,536.38.

Following deduction of claimant's attorney fees and costs, the settlement's remaining balance totalled $71,463.62. After reducing the remaining balance by the statutory one-third share under ORS 656.593(3) and 656.593(1)(b), the amount of the settlement subject to SAIF's statutory lien equals $47,642.41. SAIF's lien for its actual costs currently totals $67,647.37. Because SAIF's actual costs exceed its maximum distributive statutory share from the remaining balance of the settlement, SAIF does not assert a lien for future expenditures.

CONTENTIONS

A conflict has arisen because the parties disagree as to what portion of the settlement SAIF's lien should apply. SAIF contends that its lien attaches to the settlement before distribution of the proceeds by the probate court to the decedent's adult children. Claimant asserts that the lien attaches after the probate court's distribution of funds.

CONCLUSIONS

Pursuant to ORS 656.578, if a worker receives a compensable injury due to the negligence or wrong of a third person, entitling the worker under ORS 656.154 to seek a remedy against such third person, such worker or, if death results from the injury, the other beneficiaries shall elect whether to recover damages from the third person. If the worker or the beneficiaries of the worker elect to recover damages from the third person, notice of such election shall be given to the paying agency. ORS 656.593(1). The proceeds of any damages recovered from a third

person by the worker or beneficiaries shall be subject to a lien of the paying agency. id. The paying agency's lien shall be preferred to all claims except the cost of recovering damages from the third party. ORS 656.580(2).

If the worker or beneficiaries settle the third party claim with agency approval, the agency is authorized to accept as its share of the proceeds "an amount which is just and proper," provided the worker receives at least the amount to which he is entitled under ORS 656.593(1) and (2). ORS 656.593(3); Estate of Troy Vance v. Williams, 84 Or App 616, 619-20 (1987). "Benificiary" means an injured worker, and the husband, wife, child or dependent of a worker, who is entitled to receive payments under Chapter 656. ORS 656.005(3).

Claimant argues that only her share of the settlement following final distribution by the probate court is subject to SAIF's lien. We disagree.

We addressed a similar issue in Mario Scarino, 39 Van Natta 663 (1987). In Scarino, as personal representative for her deceased husband's estate, the claimant obtained a judgment on behalf of the estate against a third party. Thereafter, the probate department of an out-of-state court approved the claimant's request that the judgment's proceeds be distributed in equal amounts to herself and decedent's three adult children. We agreed with the claimant's contention that the children's share of the decedent's estate would not be subject to SAIF's statutory lien. However, we concluded that the children's share of the estate could neither be calculated nor distributed until SAIF's lien was applied to the judgment's proceeds.

In Scarino, we reasoned that the judgment was not awarded to a specific beneficiary and that no "earmarking" of proceeds occurred until after SAIF's lien had successfully attached. Furthermore, we acknowledged that the claimant, as personal representative for the estate, had the prerogative of distributing proceeds from the judgment in any lawful fashion. Yet, we maintained that she could do so only after complying with the statutory obligations created by her election to seek redress from a third party.

Here, claimant seeks to distinguish Scarino. Specifically, she asserts that ORS 30.020 sets forth the statutory basis for a wrongful death action and expressly articulates that such an action is brought by the personal representative of the decedent for the benefit of the surviving spouse and children. Since the surviving children are adults, claimant argues that they are not statutory beneficiaries under ORS 656.005(3). In addition, claimant cites ORS 30.040 which provides that proceeds of settlements from such actions shall be apportioned by the probate court to each beneficiary in accordance with the beneficiary's loss.

We agree that the decedent's grown children are not "beneficiaries" as defined in ORS 656.005(3). Consequently, they will neither receive workers' compensation benefits as a result of the decedent's death nor will their share of the decedent's estate be subject to SAIF's statutory lien. However, the children's share of the estate cannot be calculated and distributed until SAIF's lien against the cause of action is applied to the third party recovery. See ORS 656.580(2); Scarino, supra; at page 664.

Final distribution of the decedent's estate is subject to the jurisdiction of the probate court pursuant to ORS 30.040. Yet, prior to this final distribution of damages to the estate's beneficiaries, the personal representative is required to make payment or reimbursement for litigation costs, medical charges, and burial services rendered for the decedent. See ORS 30.030(2), (3). Reimbursement of SAIF's third party claim costs for the aforementioned services, to the level recoverable under ORS 656.593, would be included within this provision. Furthermore, considering the preferential treatment accorded a paying agency's lien against a third party cause of action pursuant to ORS 656.580(2) and the express language of ORS 656.593, we conclude that those portions of SAIF's claim costs which are not related to either medical or burial services are likewise recoverable from the settlement's proceeds.

Had claimant chosen not to initiate a third party action, her election would have operated as an assignment to the paying agency of the deceased worker's cause of action against the third person. ORS 656.591(1). Had this been the case, all proceeds of the third party recovery would have been subject to the paying agency's lien. See ORS 656.591(2). However, as legal representative of the deceased worker, claimant elected to bring suit against the third party. Consequently, upon settlement of the cause of action, the proceeds of the damages recovered from the third party by claimant, on behalf of the decedent's estate, are subject to the distribution scheme as set forth in ORS 656.593.

Accordingly, we conclude that the following distribution of proceeds from the third party settlement is "just and proper." See ORS 656.593(3). After distribution of claimant's attorney fees of $40,000 and litigation costs of $8,536.38, claimant, on behalf of the deceased worker's estate, is entitled to a statutory 1/3 share of the remaining balance of the settlement's proceeds. ie, $23,821.21. The remaining portion of the settlement's proceeds, $47,642.41, shall be distributed to the SAIF Corporation.

IT IS SO ORDERED.

KATHRYN E. LUND, Claimant
Jack Ofelt, Jr., Claimant's Attorney
Beers, Zimmerman & Rice, Defense Attorneys
Roberts, et al., Defense Attorneys

WCB 84-13179 & 85-13116
April 8, 1988
Order Denying Motion to Reconsider

Claimant has requested reconsideration of the Board's April 7, 1987 order that affirmed a Referee's order which found Liberty Northwest Insurance Company responsible for claimant's current right wrist and arm condition. Specifically, she reiterates an earlier request for an attorney fee for her counsel's services on Board review. The Board has previously declined to reconsider its order.

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

Inasmuch as the Board's April 7, 1987 order has neither been appealed, abated, stayed, nor republished, it has become

final by operation of law. Accordingly, the Board lacks jurisdiction to consider claimant's request.

IT IS SO ORDERED.

CLARENCE W. MISENHIMER, Claimant
Alice M. Bartelt, Defense Attorney
Davis & Bostwick, Defense Attorneys

WCB 87-03439 & 86-09600
April 8, 1988
Order of Dismissal

Argonaut Insurance has moved the Board for an order dismissing claimant's request for review on the ground that copies were not timely mailed to the parties. The motion is granted.

FINDINGS

The Referee's order issued February 2, 1988. Claimant's request, dated "February 1, 1988" and containing a postmark date of March 1, 1988, was received by the Board on March 2, 1988. The request did not include an acknowledgment of service or a certificate of personal service by mail upon the employer, its insurer, or its attorney.

In the request, claimant stated that he was no longer represented by counsel and lacked the funds "to send letters to all of the other parties." However, he noted that copies of his request would be provided to his state representative and the Governor's office. On March 4, 1988, the Board mailed a computer-generated letter to all parties acknowledging the request. After receiving the acknowledgment, Argonaut's counsel asked the Board for a copy of the request. Neither Argonaut nor its counsel received a copy of the request until March 10, 1988.

CONCLUSIONS

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

Here, the thirtieth day after the Referee's February 2, 1988 order was March 3, 1988. Thus, claimant's request for Board review, received by the Board on March 2, 1988, was timely filed. However, neither the employer nor its representatives were timely provided with, 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 v. King, supra.

We are mindful that claimant has apparently requested review without benefit of legal representation. We further realize that an unrepresented party is not expected to be familiar with administrative and procedural requirements of the Workers' Compensation Law. Yet, we are not free to relax a jurisdictional requirement, particularly in view of Argonaut Insurance Co. v. King, supra. See Nancy J. Schelin, 39 Van Natta 437 (1987);

Alfred F. Puglisi, 39 Van Natta 310 (1987); Julio P. Lopez, 38 Van Natta 862 (1986).

Accordingly, the request for Board review is dismissed.

MARVIN L. MOUSTACHETTI, Claimant
Quintin B. Estell, Claimant's Attorney
Merrily McCabe (SAIF), Defense Attorney

WCB 87-04966
April 8, 1988
Second Order of Remand

On March 18, 1988, we issued an order remanding this matter for consolidation with a hearing which was then pending before the Hearings Division in WCB Case No. 88-01589. Since the issuance of that order, we have learned that the aforementioned hearing has been dismissed with prejudice pursuant to the parties' stipulation.

Considering the parties' stipulation in WCB Case No. 88-01589, consolidation of these cases is no longer appropriate. Consequently, that portion of our order which directed that the cases be consolidated is withdrawn. However, we continue to conclude that this matter should be remanded to the Referee for further action consistent with our March 18, 1988 order.

Accordingly, our March 18, 1988 order is withdrawn. On reconsideration, except as modified herein, our prior order is adhered to and republished in its entirety, effective this date.

IT IS SO ORDERED.

RALPH L. THOMPSON, Claimant
SAIF Corp Legal, Defense Attorney

Own Motion 88-0099M
April 8, 1988
Own Motion Order

SAIF Corporation has submitted to the Board claimant's claim for an alleged worsening of his April 24, 1978 industrial injury. Claimant's aggravation rights have expired. SAIF opposes claim reopening for the payment of temporary total disability as claimant's treatment was diagnostic only and he has not been a part of the work force recently.

Pursuant to ORS 656.278(1)(a) we may exercise our own motion authority when we find that there is a worsening of a compensable injury that requires either inpatient or outpatient surgery or other treatment requiring hospitalization. Dr. Oltman's report of January 13, 1988 indicates that claimant was hospitalized on October 12, 1987 for treatment of pain. The examining or treating doctors have not authorized temporary total disability compensation for claimant. The evidence also indicates that claimant has been receiving Social Security benefits since 1980, thereby causing us to conclude that claimant has not been gainfully employed during that time. Under Cutright v. Weyerhaeuser Company, 299 Or 290 (1985), claimant would not be entitled to compensation for temporary total disability compensation. We conclude the request for own motion relief must be denied.

IT IS SO ORDERED.

LEONILA C. UTRERA, Claimant
Malagon & Moore, Claimant's Attorneys
Peter O. Hansen, Attorney
Gail Gage (SAIF), Defense Attorney

WCB 85-14220
April 8, 1988
Order on Remand

This matter is before the Board on remand from the Court of Appeals. Utrera v. Dept. of General Services, 89 Or App 114 (1987). The court has concluded that claimant's psychological condition was not medically stationary at the time of claim closure. Consequently, it has reversed the Board's order that found that the claim had not been prematurely closed.

Consistent with the court's opinion, the November 28, 1985 Determination Order is set aside as premature and the claim is remanded to the SAIF Corporation for processing according to law.

IT IS SO ORDERED.

JOHN P. KLEGER, Claimant
Roger D. Wallingford, Claimant's Attorney
Richard C. Pearce, Defense Attorney

WCB 87-04131
April 11, 1988
Amended Order on Review

Reviewed by Board Members Ferris and Johnson.

The insurer's counsel seeks Board authorization of a client-paid fee for services rendered which culminated in our March 11, 1988 Order on Review.

After review of the statement of services and the attorney referral letter submitted by the insurer's counsel and considering the factors set forth in OAR 438-15-010(6), we approve a client-paid fee, not to exceed $3,229.97.

Accordingly, our March 11, 1988 order is abated and withdrawn. As amended herein, we adhere to and republish our March 11, 1988 order in its entirety. The parties' rights of appeal shall run from the date of this order.

IT IS SO ORDERED.

SHARON K. SALZER, Claimant
Francesconi & Associates, Claimant's Attorneys
Rankin, et al., Defense Attorneys

WCB 85-12483
April 11, 1988
Order on Reconsideration

This matter is before the Board on remand from the Court of Appeals. Pursuant to the court's March 11, 1988 order, we have been directed to reconsider this case in light of new medical evidence contained in WCB Case No. 87-06505, a case which is presently pending Board review.

Our scope of review is limited to consideration of the reasonableness and necessity of claimant's denied low back surgery. The scope of our review expressly excludes consideration of claimant's request for claim reopening and time loss. In conducting our review, we have considered the medical evidence generated after the record closed in WCB Case No. 85-12483. As previously mentioned, this evidence is present in WCB Case No. 87-06505 and is contained in that case's record between Exhibits 40 through 64.

FINDINGS

In May 1978 claimant suffered a compensable lumbosacral strain. After approximately four months of conservative treatment, she returned to regular work. A July 1979 Determination Order closed her claim with an award of temporary disability only.

In February 1985, claimant began treating with Dr. Berselli, neurologist. Following a series of diagnostic tests and conservative measures, Berselli suggested an injection of chymopapain into claimant's L5-S1 disc space. Berselli's request prompted consulting opinions from four physicians, two of whom recommended a laminectomy and fusion. The physicians who concluded that claimant would benefit from surgery were Drs. Misko and Parsons. Dr. Rosenbaum and Dr. Reimer, claimant's former treating physician, did not recommend surgery.

The surgery issue arose out of claimant's request for hearing from the self-insured employer's denial of her aggravation claim. In October 1986, Referee Podnar found the surgery compensable and directed the employer to authorize the surgery. The employer requested Board review of the Referee's order.

In November 1986, Dr. Berselli administered the injection. Yet, claimant's symptoms remained unchanged, prompting Dr. Berselli to request authorization for surgery in February 1987. Claimant subsequently requested a hearing, which was scheduled for November 1987 before Referee Podnar in WCB Case No. 87-06505.

Meanwhile, the Board proceeded to review the Referee's October 1986 order in WCB Case No. 85-12483. On March 25, 1987, the Board found that claimant had failed to prove the necessity of her proposed surgery. Consequently, the Board reversed that portion of the Referee's order that had directed the employer to authorize the surgery. In reaching its decision, the Board primarily relied on the previous opinions of Dr. Berselli, claimant's current treating physician, and Dr. Reimer, claimant's former treating physician. Claimant sought judicial review of the Board's order.

The issue of claimant's proposed surgery in WCB Case No. 87-06505 proceeded to hearing. Relying on the Board's order in WCB Case No. 85-12483, Referee Podnar upheld the employer's denial of surgery. Claimant requested Board review.

We find the proposed surgery reasonable and necessary medical treatment resulting from claimant's compensable injury.

CONCLUSIONS

For every compensable injury, the insurer/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. ORS 656.245(1). To establish the compensability of her claim for medical services, claimant must prove that the proposed surgery is reasonable and necessary as a result of her compensable injury. Wetzel v. Goodwin Brothers, 50 Or App 101 (1981); McGarry v. SAIF, 24 Or App 883 (1976).

In reaching our previous conclusion that the proposed surgery was not compensable, we primarily relied upon the opinions of claimant's current and former treating physicians, Drs. Berselli and Reimer. At the time the record was closed in WCB Case No. 85-12483, both physicians had concluded that surgery was not warranted. Since the closure of the record in WCB Case No. 85-12483, Dr. Berselli has opined that surgery is required and has requested authorization to perform the operation. Berselli bases his opinion on the failure of the chymopapain injection to relieve claimant's continuing symptoms from the central disc protrusion and degeneration in her lower back. Dr. Reimer continues to question claimant's need for a laminectomy and fusion. However, he supports surgical intervention, if only for exploration purposes.

Absent persuasive reasons to the contrary, we generally accord greater weight to the treating physician. Weiland v. SAIF, 64 Or App 810 (1983). Finding no persuasive reason to discount his opinion, we continue to rely upon the conclusions and reasoning expressed by Dr. Berselli, claimant's current treating physician. We further note that Berselli's surgery recommendation is supported by two consulting physicians, and, at least for exploration purposes, Dr. Reimer, claimant's former treating physician.

Accordingly, our March 25, 1987 Order on Review is withdrawn. After reconsidering this record, in light of the new medical evidence contained in WCB Case No. 87-06505, we conclude that the proposed surgery is reasonable and necessary medical treatment resulting from claimant's compensable injury. Consequently, the proposed surgery is compensable.

Claimant's attorney is statutorily entitled to a reasonable, carrier-paid attorney fee for services rendered on review. See ORS 656.382(2). Such a fee is defined as an "assessed fee." OAR 438-15-005(2). However, we cannot authorize an assessed fee unless claimant's counsel files a statement of services. See OAR 438-15-010(5). Inasmuch as no statement of services has been filed to date, an assessed fee for services on Board review cannot be awarded.

ORDER

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

SHARON K. SALZER, Claimant
Francesconi & Associates, Claimant's Attorneys
Rankin, et al., Defense Attorneys

WCB 87-06505
April 11, 1988
Order on Review

Reviewed by Board Members Johnson and Ferris.

Claimant requests review of Referee Podnar's order that upheld the self-insured employer's denial of claimant's proposed low back surgery. On review, the issue is the compensability of the proposed surgery. We reverse.

FINDINGS

This matter was reviewed in consolidation with WCB Case No. 85-12483, pursuant to the Court of Appeals' March 11, 1988

remand order in that case. This date, on remand from the court in the aforementioned case, we have found the proposed surgery compensable. The findings and conclusions reached in our order in WCB Case No. 85-12483 are incorporated herein by this reference.

CONCLUSIONS

Inasmuch as the proposed surgery has been found compensable in WCB Case No. 85-12483, it follows that the same proposed surgery is compensable in this case. Consequently, for the reasons set forth in our Order on Reconsideration in WCB Case No. 85-12483, we set aside the employer's denial of the proposed surgery in this case.

Claimant's attorney is statutorily entitled to a reasonable, carrier-paid attorney fee for services rendered in this matter. See ORS 656.382(2). Such a fee is defined as an "assessed fee." OAR 438-15-005(2). However, we cannot authorize an assessed fee unless claimant's counsel files a statement of services. See OAR 438-15-010(5). Inasmuch as no statement of services has been filed to date, an assessed fee cannot be awarded.

ORDER

The Referee's order dated December 10, 1987 is reversed.

CONRAD DELANOY, JR., Claimant
Dennis H. Henninger, Claimant's Attorney
SAIF Corp Legal, Defense Attorney

Own Motion 88-0106M
April 12, 1988
Own Motion Order

SAIF Corporation has submitted to the Board claimant's claim for an alleged worsening of his July 2, 1979 industrial injury. Claimant's aggravation rights have expired. SAIF opposes reopening for the payment of temporary total disability as claimant has withdrawn himself from the work force.

Pursuant to ORS 656.278(1)(a), we may exercise our own motion authority only when we find that there is a worsening of a compensable injury that requires either inpatient or outpatient surgery or other treatment requiring hospitalization. Hospitalization for treatment and/or surgery have not been recommended at this time. We are, therefore, precluded by law from reopening this claim for the payment of temporary total disability compensation. Claimant's apparent withdrawal from the work force could also preclude him from receiving any benefits under ORS 656.278. The request for own motion relief must be denied.

IT IS SO ORDERED.

DEWEY L. DIETZ, Claimant
Breathouwer, et al., Claimant's Attorneys

Own Motion 88-0101M
April 12, 1988
Own Motion Order

The insurer has submitted to the Board claimant's claim for an alleged worsening of his May 7, 1980 industrial injury. Claimant's aggravation rights have expired. The insurer has indicated a willingness to reopen claimant's claim.

Pursuant to ORS 656.278(1)(a), we may exercise our own motion authority when we find that there is a worsening of a compensable injury that requires either inpatient or outpatient surgery or other treatment requiring hospitalization.

Thorough review of this case indicates that Dr. Sulkosky took claimant off work in November 1987 for approximately two weeks. Neither surgery nor hospitalization was recommended at this time. We are, therefore, precluded from reopening this claim for the payment of temporary total disability compensation. The request for own motion relief is hereby denied.

IT IS SO ORDERED.

GREG CARPENTER, Claimant
Merrill Schneider, Claimant's Attorney
Nelson, et al., Defense Attorneys

WCB 87-12941
April 14, 1988
Order Withdrawing Order of Dismissal

Claimant has requested reconsideration of our March 16, 1988 order, which dismissed his request for Board review of the Referee's January 22, 1988 order as untimely filed. Since the request was neither mailed by registered nor certified mail and was received on February 23, 1988, after the date for filing, it was presumed to be untimely until claimant established that the mailing was timely. See OAR 438-05-046(1)(b). Enclosing an affidavit which states that the request for review was timely mailed to the Board, claimant asks that the dismissal order be withdrawn.

FINDINGS

Based on claimant's attorney's affidavit and the record as a whole, we find that the request for Board review was mailed on February 22, 1988. Therefore, the request was timely mailed.

CONCLUSION

Inasmuch as claimant has established that his request for review was timely mailed, the presumption of untimeliness has been overcome. See OAR 438-05-046(1)(b). Accordingly, the Board's March 16, 1988 dismissal order is withdrawn. Claimant's request for Board review shall be acknowledged and a hearing transcript ordered. Upon receipt of the transcript, copies will be provided to the parties and a briefing schedule implemented.

IT IS SO ORDERED.

DEWEY DAVIS, Claimant
Merrill Schneider, Claimant's Attorney

Own Motion 88-0058M
April 14, 1988
Own Motion Order

The insurer has submitted to the Board for evaluation claimant's October 22, 1982 nondisabling back injury claim. Claimant objects to the insurer's request, contending that this claim has never been closed. Consequently, he argues that we lack jurisdiction to consider this matter. After reviewing this matter, we agree with claimant and refer this claim to the insurer for closure.

FINDINGS

On October 22, 1982, claimant sustained a compensable "back strain" injury while performing his custodian duties. On October 27, 1982, he sought medical treatment and filed his claim, noting that he had not returned to his next scheduled shift following the injury. Claimant was released for regular work on October 29, 1982. He has not sought treatment for his compensable injury since April 1983. His claim has neither been closed administratively nor through the Evaluation Division.

In January 1988 claimant requested claim closure under ORS 656.268(3). Asserting that claimant's aggravation rights had expired, the insurer referred the claim to the Board for determination pursuant to ORS 656.278.

CONCLUSIONS

At the time of claimant's compensable injury, ORS 656.268(3) provided that claims for nondisabling injuries or disabling injuries without permanent disability could be closed either through a Notice of Closure or by means of a Determination Order. In any event, closure of a claim was required, whether disabling or nondisabling. See Webb v. SAIF, 83 Or App 386, 390 (1987) (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.).

In addition, 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/employer should immediately report the claim to the director. 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. id. 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).

The interplay of these statutes was discussed in Davison v. SAIF, 80 Or App 541, modified on recon 82 Or App 546 (1986). In Davison, the claimant lost a small portion of his little finger. His 1982 injury claim was accepted as nondisabling. The claimant did not seek reclassification of the injury within the required one year period. Eventually, the claimant sought reclassification, contending that his claim had never been formally closed either administratively or by Determination Order. The Davison court found that the claim had been misclassified from the outset. Thus, ORS 656.262(12) did not apply. Furthermore, the court concluded that SAIF's notice of acceptance did not comply with the notice of closure requirements of ORS 656.268(3). Since the claim had never been closed, the court reasoned that the claimant's right to seek a determination order had not expired.

These statutes were also addressed in Smith v. Ridgepine, Inc., 88 Or App 147 (1987). In Smith, claimant suffered a 1980 compensable low back injury. She sought medical treatment, but there was no indication that she missed time from work. Her claim was accepted as nondisabling. This classification was not contested and there was no suggestion that the claim was misclassified. The claim was apparently neither closed by Notice of Closure or Determination Order. More than five years after the date of injury, claimant's treating physician requested time loss. Applying former ORS 656.262(10) (now ORS 656.262(12)) and ORS 656.273(4)(b), the Smith court concluded that the "aggravation claim" was barred because it was not filed within five years of claimant's compensable injury.

We conclude that this case is governed by Davison, rather than Smith. Here, as in Davison, insurers/employers were required to close nondisabling injury claims. We note

parenthetically that carrier closures of nondisabling claims were also required at the time of the claimant's injury in Smith. However, in Smith, the "closure" issue was apparently not raised.

The key factor which brings this case within the Davison, as opposed to the Smith, holding is that the claim was misclassified from its inception. The record establishes that claimant missed time from work as a result of his compensable injury. Inasmuch as he sustained time loss, his claim should not have been classified as nondisabling. See ORS 656.005(8)(b), (c). Therefore, as was the case in Davison, the claim has been misclassified from the outset. Because of this misclassification, ORS 656.262(12), 656.273(4)(b), and the Smith court's rationale, do not apply.

Accordingly, we conclude that claimant's 1982 injury claim remains open because it has never been closed by a Notice of Closure or Determination Order. See ORS 656.268(3); Davison v. SAIF, supra. Because we lack jurisdiction to consider this matter further, this claim is referred to the insurer for closure either administratively or through the Evaluation Division.

IT IS SO ORDERED.

LORRAINE DORINGER, Claimant
Velure & Yates, Claimant's Attorneys
SAIF Corp Legal, Defense Attorney

Own Motion 88-0121M
April 14, 1988
Own Motion Order

SAIF Corporation has submitted to the Board claimant's claim for an alleged worsening of her June 25, 1977 industrial injury. Claimant's aggravation rights have expired. SAIF opposes reopening as it contends claimant has removed herself from the work force and there is only palliative treatment recommended at this time.

Although claimant argues to the contrary, the evidence would indicate that she has not been gainfully employed since 1983 and, therefore, would not be entitled to compensation for temporary total disability even if she were able to satisfy the requirements of ORS 656.278. However, claimant's request for relief must also be denied under the new own motion law which took effect January 1, 1988. Pursuant to ORS 656.278(1)(a), we may exercise our own motion authority when we find that there is a worsening of a compensable injury that requires either inpatient or outpatient surgery or other treatment requiring hospitalization. None of the above treatment modalities have been recommended to claimant at this time. We conclude claimant's request for own motion relief must be denied.

IT IS SO ORDERED.

EDWIN L. KELLER, Claimant
Tamblyn & Bush, Claimant's Attorneys
Randolph Harris (SAIF), Defense Attorney
Carl M. Davis, Ass't. Attorney General

WCB 87-09000
April 14, 1988
Amended Order of Dismissal
(Remanding)

On March 4, 1988, the SAIF Corporation filed its request for Board review of Referee Mulder's February 5, 1988 order. That same day, Referee Mulder issued an Order of Abatement. Relying on the Referee's abatement order, SAIF then withdrew its request for review.

FINDINGS

On March 21, 1988, we dismissed SAIF's request for review. However, the dismissal order neglected to mention that the withdrawal of SAIF's request for review was expressly conditioned upon our returning the case to the Referee for further action.

Based on the aforementioned findings, we conclude that our prior order should be withdrawn. In its place, we issue the following amended order.

CONCLUSION

Where simultaneous acts affect the vesting of jurisdiction in this forum, in the interest of administrative economy and substantial justice, we will give effect to the act that results in the resolution of the controversy at the lowest possible level. James D. Whitney, 37 Van Natta 1463 (1985).

Inasmuch as the Referee abated his order simultaneously with SAIF's request for Board review, we shall give effect to the Order of Abatement. Accordingly, the request for review is dismissed as premature. This matter is remanded to the Referee for further consideration.

IT IS SO ORDERED.

TRACY KLEIN, Claimant
SAIF Corp Legal, Defense Attorney

Own Motion 87-0704M
April 14, 1988
Own Motion Determination on Reconsideration

The Board issued an Own Motion Determination on December 11, 1987 whereby claimant's claim was closed with no additional award for permanent partial disability. Claimant asks the Board to reconsider its order and increase his prior award by 10 percent.

Claimant's claim is currently in a closed status and, as such, must be considered under the new law which took effect on January 1, 1988. Under the new law, the Board is not authorized to allow additional permanent disability awards in those claims which are beyond the five-year aggravation period. ORS 656.278(1)(a). The request for further relief must be denied.

IT IS SO ORDERED.

PAUL LENOCKER, Claimant
Charles D. Maier, Claimant's Attorney

Own Motion 87-0624M
April 14, 1988
Own Motion Determination on Reconsideration

The Board issued an Own Motion Determination on November 10, 1987 whereby claimant's claim was closed with no award for permanent partial disability granted. On March 11, 1988 claimant requested that the Board reconsider its order and grant him an award for permanent disability. The insurer has not responded to claimant's request.

Claimant's claim is currently in a closed status and, as such, must be considered under the new law which took effect on January 1, 1988. The law specifically states when the Board can exercise its own motion authority. ORS 656.278(1)(a). There is no provision in the law for granting increased awards for permanent disability once the worker's aggravation rights have expired. We must decline claimant's request for further relief.

IT IS SO ORDERED.

CAROL A. McNAUGHT, Claimant
Emmons, et al., Claimant's Attorneys
Garrett, et al., Defense Attorneys

Own Motion 88-0134M
April 14, 1988
Own Motion Order

The insurer has submitted to the Board claimant's claim for an alleged worsening of her August 6, 1981 industrial injury. Claimant's aggravation rights have expired. The insurer opposes reopening of this claim as it contends claimant's current condition is not related to the 1981 industrial injury. A denial of responsibility was issued by the insurer on February 22, 1988.

A hearing on the denial is currently pending in the Hearings Division. The Board's general policy in these types of situations has been to postpone action on the request for own motion relief until resolution of the pending hearing. However, after a review of the evidence before us, we find that claimant would not be entitled to temporary total disability benefits even were the Referee to rule in her favor. Pursuant to ORS 656.278(1)(a), we may exercise our own motion authority when we find that there is a worsening of a compensable injury that requires either inpatient or outpatient surgery or other treatment requiring hospitalization. None of the above treatment modalities have been suggested to claimant at this time. We conclude, no matter what the outcome at hearing, claimant would not be entitled to claim reopening under ORS 656.278 for the payment of temporary total disability. Should the outcome of the pending hearing be in claimant's favor and should her treatment plan change in the future, claimant may again ask the Board for own motion relief. Based on the current record, the request for own motion relief must be denied.

IT IS SO ORDERED.

DALE L. ORWICK, Claimant
Cowling & Heysell, Defense Attorneys

WCB 86-16031
April 14, 1988
Order on Review

Reviewed by Board Members Crider and Johnson.

Claimant requests review of Referee McCullough's order which: (1) awarded a $250 attorney fee for services rendered in provoking the retraction of the insurer's partial denial of his medical services claim for a left hip injury prior to hearing; and (2) assessed a $100 attorney fee for the insurer's unreasonable denial of the claim and its unreasonable delay in providing complete discovery. On review, claimant contends that he is entitled to reimbursement for: (1) wages lost as a result of his attendance at the hearing; and (2) his physician's fee for preparing a medical report for hearing. The sole issue on review is reimbursement of litigation costs.

We affirm and adopt the Referee's order with the

following comment. The Referee did not address, and could not have addressed, the issue of claimant's entitlement to reimbursement for hearing costs because the issue was not raised at hearing. It will not be considered on Board review. See e.g., Brian J. Shaw, 39 Van Natta 438 (1987). Further, even assuming this issue was properly before us, there is no authority supporting claimant's request for reimbursement. We have held that litigation costs are not recoverable under ORS 656.386(1). Patricia M Anderson, 36 Van Natta 588 (1984).

The insurer's counsel seeks Board authorization of a client-paid fee for services rendered on Board review. After reviewing the statement of services and attorney retention agreement submitted by the insurer's counsel and considering the factors set forth in OAR 438-15-010(6), we approve a client-paid fee, not to exceed $250.

ORDER

The Referee's order dated May 28, 1987 is affirmed. A client-paid fee not to exceed $250 is approved.

ELNORA SPRAGUE, Claimant
Fitzwater & Fitzwater, Claimant's Attorneys

Own Motion 88-0100M
April 14, 1988
Own Motion Order

The insurer has submitted to the Board claimant's claim for an alleged worsening of her November 30, 1977 industrial injury. Claimant's aggravation rights have expired. Claimant specifically seeks compensation for permanent total disability. The insurer opposes the relief claimant seeks.

Under the new law, which became effective January 1, 1988, the Board own motion authority has been restricted. There is no provision in the new law for the issuance of permanent disability awards to injured workers whose aggravation rights have expired. ORS 656.278(1)(a). The request for own motion relief must be denied.

IT IS SO ORDERED.

KENNETH M. DOGGETT, Claimant
SAIF Corp Legal, Defense Attorney

Own Motion 88-0038M
April 15, 1988
Own Motion Order on Reconsideration

The Board issued an Own Motion Order on February 9, 1988 whereby claimant's request for temporary total disability compensation during his recovery from surgery was denied as it was found he had removed himself from the work force. Claimant has asked the Board to reconsider its order, submitting additional evidence to show that he had, in fact, looked for work prior to his recent surgery.

Following our review of the new evidence, we are persuaded that claimant has shown he was looking for work prior to his recent aggravation. We conclude he is entitled to compensation for temporary total disability during his recovery from surgery in accordance with ORS 656.278(1)(a). Accordingly, claimant's claim is hereby reopened with temporary total disability to commence the date of the surgery and to continue

until claimant returns to his regular work at his regular wage or is medically stationary, whichever is earlier. Reimbursement from the Reopened Claims Reserve is authorized to the extent allowed under ORS 656.625 and OAR 436, Division 45. When appropriate, the claim shall be closed by the insurer pursuant to OAR 438-12-055.

IT IS SO ORDERED.

OLEN B. HAMMONS, Claimant
SAIF Corp Legal, Defense Attorney

Own Motion 88-0105M
April 15, 1988
Own Motion Order

SAIF Corporation has submitted to the Board claimant's claim for an alleged worsening of his April 17, 1979 industrial injury. Claimant's aggravation rights have expired. SAIF opposes reopening for the payment of disability benefits as no surgery has been recommended and current treatment is on a diagnositic basis.

Pursuant to ORS 656.278(1)(a), we may exercise our own motion authority only when we find that there is a worsening of a compensable injury that requires either inpatient or outpatient surgery or other treatment requiring hospitalization. None of the above have been recommended in this case. Claimant's request for relief could be construed to be a request for permanent disability benefits, including possible permanent total disability. However, the new law, which took effect January 1, 1988, no longer gives us the authority to allow increased awards. We conclude the request for own motion relief must be denied.

IT IS SO ORDERED.

WAYNE L. NEWMAN, Claimant
Burt, Swanson, et al., Claimant's Attorneys
Beers, et al., Defense Attorneys

WCB 85-06437
April 15, 1988
Order on Review
Reviewed by Board Members Ferris and Johnson.

Claimant requests review of those portions of Referee Emerson's order that: (1) rejected his contention that his claim for a right shoulder and upper arm injury was prematurely closed; (2) upheld the insurer's "de facto" denial of an alleged aggravation claim for the same condition; and (3) rejected his request for awards of scheduled and unscheduled permanent partial disability for the condition. The issues are premature closure, aggravation and extent of disability.

The Board affirms and adopts the order of the Referee with the following comment on the premature closure issue. The Referee stated that the propriety of claim closure must be judged on the basis of the evidence available to the Evaluation Division at the time of claim closure, citing Alvarez v. GAB Business Services, 72 Or App 522 (1985). Since the Referee issued his order, the court has made it clear that evidence not available to the Evaluation Division may be considered in determining the propriety of claim closure. Utrera v. Dept. of General Services, 89 Or App 114, 116 (1987); Scheuning v. J.R. Simplot & Co., 84 Or App 622, 625, rev den 303 Or 590 (1987). Changes in a claimant's condition after claim closure, however, still may not be considered. Id. at 625 & n.5.

ORDER

The Referee's order dated March 16, 1987 is affirmed.

LELAND SMITH, JR., Claimant
Huffman, et al., Claimant's Attorneys
SAIF Corp Legal, Defense Attorney
Schwabe, et al., Defense Attorneys

Own Motion 87-0418M
April 15, 1988
Own Motion Order

SAIF Corporation has submitted to the Board claimant's claim for an alleged worsening of his June 14, 1977 industrial injury. Claimant's aggravation rights have expired. SAIF initially denied responsibility for the condition, contending claimant's problems were the result of a new injury. This was litigated at hearing with the Referee finding SAIF responsible for claimant's condition under the 1977 claim, a finding with which the Board concurs. The Referee has recommended to the Board that it reopen the 1977 claim and provide claimant time loss benefits for his worsened condition. No appeal has been filed on the Referee's order and it is now final by operation of law. Claimant now seeks temporary total disability compensation for his inability to work commencing April 1, 1987.

Pursuant to ORS 656.278(1)(a), we may exercise our own motion authority when we find that there is a worsening of a compensable injury that requires either inpatient or outpatient surgery or other treatment requiring hospitalization. In such cases, we are authorized to award temporary disability compensation commencing from the time the worker is actually hospitalized or undergoes outpatient surgery.

Claimant's condition worsened in December 1986 and resulted in time off work from April 1987. Surgery has not been recommended. The only hospitalization involved was on May 20, 1987 when claimant underwent a myelogram. Hospitalization for treatment of claimant's back has not been recommended. We conclude, therefore, that we must disagree with the recommendation of the Referee as we are without authority to reopen claimant's claim for the payment of temporary total disability compensation. ORS 656.278(1)(a). The request for own motion relief must be denied.

IT IS SO ORDERED.

JOHN THISSELL, Claimant
SAIF Corp Legal, Defense Attorney

Own Motion 88-0171M
April 15, 1988
Own Motion Order

SAIF Corporation has submitted to the Board claimant's claim for an alleged worsening of his February 25, 1977 industrial injury. Claimant's aggravation rights have expired. SAIF has authorized the recommended surgery and recommends that claimant's claim be reopened for the payment of temporary total disability compensation.

Claimant has been receiving temporary total disability compensation in a separate claim. The Board's February 2, 1988 Own Motion Order in a 1976 SAIF claim allowed him benefits from the date of the right knee surgery. Claimant was last seen by his doctor on March 30, 1988, at which time his doctor indicated that his right knee condition was medically stationary. SAIF closure of the 1976 claim will terminate benefits as of March 30, 1988.

Claimant underwent surgery for his left knee on February 19, 1988. Pursuant to ORS 656.278(1)(a), we may exercise

our own motion authority when we find that there is a worsening of a compensable injury that requires either inpatient or outpatient surgery or other treatment requiring hospitalization. In such cases, we are authorized to award temporary disability compensation comencing from the time the worker is actually hospitalized or undergoes outpatient surgery.

Following our review of this record, we do not feel it would be appropriate to commence payment of temporary total disability as of February 19, 1988, thereby resulting in the payment of double compensation. We conclude, therefore, claimant's left knee claim should be reopened with temporary total disability compensation to commence March 31, 1988 and to continue until claimant returns to his regular work at his regular wage or is medically stationary, whichever is earlier. Reimbursement from the Reopened Claims Reserve is authorized to the extent allowed under ORS 656.625 and OAR 436, Division 45. When appropriate, the claim shall be closed by the insurer pursuant to OAR 438-12-055.

IT IS SO ORDERED.

WALTER D. HENNEBERG, Claimant
Merrill Schneider, Claimant's Attorney
Mark B. Williams, Ass't. A.G., Multnomah Co.

WCB 87-13896
April 19, 1988
Order Withdrawing Order of Dismissal

The self-insured employer has requested reconsideration of our March 21, 1988 order, which dismissed its request for Board review of the Referee's January 28, 1988 order as untimely filed. Since the request was neither mailed by registered nor certified mail and was received on March 1, 1988, after the date for filing, it was presumed to be untimely until the employer established that the mailing was timely. See OAR 438-05-046(1)(b). Enclosing an affidavit which states that the request for review was timely mailed to the Board, the employer asks that the dismissal order be withdrawn.

FINDINGS

Based on the affidavits submitted by the employer's counsel and the record as a whole, we find that the request for Board review was mailed on February 26, 1988. Therefore, the request was timely mailed.

CONCLUSION

Inasmuch as the employer has established that its request for review was timely mailed, the presumption of untimeliness has been overcome. See OAR 438-05-046(1)(b). Accordingly, the Board's March 21, 1988 dismissal order is withdrawn. The employer's request for Board review shall be acknowledged and a hearing transcript ordered. Upon receipt of the transcript, copies will be provided to the parties and a briefing schedule implemented.

IT IS SO ORDERED.

MICHAEL MINSKER, Claimant

Own Motion 88-0132M
April 19, 1988
Own Motion Order

The insurer has submitted to the Board claimant's claim for an alleged worsening of his February 28, 1982 industrial injury. Claimant's aggravation rights expired on January 7, 1988. The insurer contends that claimant's condition has not materially worsened and own motion relief should be denied.

The first closure of claimant's claim was on January 8, 1983. In November 1987, within the five-year aggravation period, claimant's doctor wrote to CIGNA requesting additional medical services. No actual temporary total disability compensation was recommended until January 28, 1988. However, we find that claimant has satisfied the requirements of ORS 656.273(2), (3) and (4). It is now incumbent on CIGNA to process the claim under ORS 656.273(6). We conclude this claim is not properly before the Board under ORS 656.278 and dismiss the claimant's request for own motion relief.

IT IS SO ORDERED.

NATALIE WAGGONER, Claimant

Own Motion 88-0188M
April 19, 1988
Own Motion Order

The insurer has submitted to the Board claimant's claim for an alleged worsening of her January 13, 1974 industrial injury. Claimant's aggravation rights have expired. The insurer has authorized the recommended surgery, but opposes claim reopening for the payment of temporary total disability compensation as it contends claimant has not been in the work force recently.

Pursuant to ORS 656.278(1)(a), we may exercise our own motion authority when we find that there is a worsening of a compensable injury that requires either inpatient or outpatient surgery or other treatment requiring hospitalization. In such cases, we are authorized to award temporary disability compensation commencing from the time the worker is actually hospitalized or undergoes outpatient surgery. In this case, surgery has been recommended, tentatively scheduled for April 20, 1988.

Claimant has provided the Board with proof that she has been gainfully employed on a part time basis over the past several months. We conclude that she is entitled to claim reopening pursuant to ORS 656.278. Claimant's claim is hereby reopened with temporary total disability compensation to commence the date of the surgery and to continue until claimant returns to her regular work at her regular wage or is medically stationary, whichever is earlier. Reimbursement from the Reopened Claims Reserve is authorized to the extent allowed under ORS 656.625 and OAR 436, Division 45. When appropriate, the claim shall be closed by the insurer pursuant to OAR 438-12-055.

IT IS SO ORDERED.

ELBERTIA GOODENOUGH, Claimant
Emmons, et al., Claimant's Attorneys
SAIF Corp Legal, Defense Attorney
Kevin L. Mannix, Defense Attorney
Schwabe, et al., Defense Attorneys

Own Motion 88-0193M
April 21, 1988
Denial of Issuance of Order Designating Paying Agent (ORS 656.307)

The Compliance Division has notified the Board that it is prepared to issue an order designating a paying agent under ORS 656.307 and OAR 436-60-180. Each of the employers/insurers have provided their written acknowledgment that the only issue is responsibility for claimant's otherwise compensable claim. Claimant's aggravation rights under her claim with United Employers Insurance Company have expired. Thus, that claim is subject to ORS 656.278.

Pursuant to OAR 438-12-032(3), the Board shall notify the Compliance Division that it consents to the order designating a paying agent, if it finds that the claimant would be entitled to own motion relief if the own motion insurer is the party responsible for payment of compensation. The Board may exercise its own motion jurisdiction if there is a worsening of a compensable injury that requires either inpatient or outpatient surgery or other treatment requiring hospitalization. ORS 656.278(1)(a). In such cases, the Board may authorize the payment of temporary disability compensation from the time the worker is actually hospitalized or undergoes outpatient surgery until the worker's condition becomes medically stationary, as determined by the Board. id.

FINDINGS AND CONCLUSION IF NO CONSENT

The record fails to establish that there has been a worsening of claimant's compensable injury requiring either inpatient or outpatient surgery or other treatment requiring hospitalization. Consequently, claimant would not be entitled to own motion relief if the own motion insurer is found responsible for claimant's current condition.

Because the Board presently lacks Own Motion jurisdiction to award temporary disability compensation, it is without authority to consent to an order designating a paying agent. However, since responsibility for claimant's current condition is the only issue in dispute, the Board recommends the issuance of an order designating a paying agent pursuant to ORS 656.307(1)(b) for the payment of claimant's medical services. See OAR 436-60-180(14).

IT IS SO ORDERED.

JANELLE I. NEAL, Claimant
Larry I. Voth, Claimant's Attorney
Schwabe, et al., Defense Attorneys

WCB 87-09194
April 21, 1988
Amended Order of Dismissal

The self-insured employer's counsel seeks Board authorization of a client-paid fee for services rendered which culminated in our March 24, 1988 Order of Dismissal.

After review of the statement of services and the attorney referral letter in this particular case, and considering the factors set forth in OAR 438-15-010(6), we approve a client-paid fee, not to exceed $135. In so doing, we note that all attorney fees are subject to Board approval. OAR 438-15-001. However, costs incurred by an attorney in pursuing a matter on behalf of a party are not included

in fees paid to any attorney. OAR 438-15-005(7). Therefore, Board approval for reimbursement of costs incurred by the attorney is not required. See OAR 438-15-005(4), (5), (7); OAR 438-15-010(5).

Accordingly, our March 24, 1988 order is abated and withdrawn. As amended herein, we adhere to and republish our March 24, 1988 order in its entirety. The parties' rights of appeal shall run from the date of this order.

IT IS SO ORDERED.

FRED T. SAMPSON, Claimant
Sellers & Jacobs, Claimant's Attorneys
SAIF Corp Legal, Defense Attorney

Own Motion 87-0528M
April 21, 1988
Own Motion Order

Claimant has requested that the Board exercise its own motion authority and reopen his claim for an alleged worsening of his June 2, 1980 industrial injury. Claimant's aggravation rights have expired. SAIF Corporation issued a denial of responsibility for claimant's medical expenses, which included the surgery performed in the spring of 1987. Claimant requested a hearing on the denial and the Board subsequently postponed action on the own motion request until resolution of the pending hearing. Referee Schultz, by Opinion and Order dated January 28, 1988, directed SAIF to accept responsibility for claimant's surgery and related expenses. His order was not appealed and is now final by operation of law. Claimant again asks the Board to rule on his entitlement to compensation for temporary total disability during recovery from the surgery.

Pursuant to ORS 656.278(1)(a), we may exercise our own motion authority when we find that there is a worsening of a compensable injury that requires either inpatient or outpatient surgery or other treatment requiring hospitalization. In such cases, we are authorized to award temporary disability compensation commencing from the time the worker is actually hospitalized or undergoes outpatient surgery.

Claimant did undergo surgery in 1987 which has been found to be related to his compensable injury. Although he has not been gainfully employed for some time, we find that his claim has remained active much of the time. We conclude claimant has not voluntarily removed himself from the work force. Claimant's claim is hereby reopened with temporary total disability compensation to commence the date of surgery in April 1987 and to continue until claimant returns to his regular work at his regular wage or is medically stationary, whichever is earlier. Claimant's attorney is awarded 25% of the additional compensation granted by this order, not to exceed $500 as a reasonable attorney's fee. Reimbursement from the Reopened Claims Reserve is authorized to the extent allowed under ORS 656.625 and OAR 436, Division 45. When appropriate, the claim shall be closed by the insurer pursuant to OAR 438-12-055.

IT IS SO ORDERED.

DONALD P. BOND, Claimant
Steven C. Yates, Claimant's Attorney
Rankin, VavRosky, et al., Defense Attorneys

WCB TP-88001
April 25, 1988
Third Party Distribution Order

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

FINDINGS

In April 1984, claimant, a police officer, sustained a compensable left knee injury while tackling and subduing a suspect. This injury eventually necessitated a September 1984 arthroscopic resection of a flap tear of the medial meniscus. His condition improved post-operatively and in November 1984, his treating orthopedist, Dr. Schachner, released him to regular work with no restrictions. The claim was closed by a May 1985 Determination Order, which awarded claimant 5 percent scheduled permanent disability for the left leg (knee). This award was subsequently increased to 15 percent scheduled permanent disability by virtue of a January 1986 stipulation.

Since his injury, claimant has experienced periodic pain and swelling in the knee, primarily dependent upon the degree of his physical activity. Dr. Schachner's clinical impression is one of degenerative arthritis. Bone scan findings are consistent with early osteoarthritis in the lateral tibial plateau of the left knee. Concluding that a surgical approach is not indicated, Dr. Schachner has recommended an oral anti-inflammatory medication, Feldene, and has advised claimant to return for further examinations on an "as-needed basis."

In June 1987, with the paying agency's approval, claimant settled his third party civil action for $40,000. After deducting claimant's attorney fees, litigation costs, and the 1/3 statutory share pursuant to ORS 656.593(1)(b), the remaining balance of the recovery totalled $17,483.28. The agency's actual claim costs are $8,672.87. These costs have been fully reimbursed to the paying agency. Thus, the remaining balance of the third party settlement equals $8,810.41.

Dr. Schachner has recently addressed claimant's future need for medical services. Claimant will require routine "followup" care three times a year, provided that he continues to take the Feldene on a daily basis. This medication is presently controlling claimant's underlying arthritic condition, but if he changed to a job requiring less strenuous activity, it is possible that his need for medication could be terminated.

There is no indication that claimant plans to refrain from performing his current work activities. Consequently, we find that it is reasonably certain that claimant will require the aforementioned medical services in the future.

The charge for a routine examination by Dr. Schachner is $30. Based on Dr. Schachner's projection of three visits per year, the paying agency foresees an annual bill of $90. The cost for 15 tablets of Feldene is currently $28, or $1.87 per tablet. Since claimant is taking this medication daily, the annual

prescription bill would total $682.55. [We note parenthetically that the paying agency's projection contains an error in that it states that $1.87 multiplied by 365 equals $681]. When these projections are combined, the annual cost for claimant's future medical treatment resulting from his compensable injury is $772.55.

At 39 years of age, claimant has a life expectancy of 34.5 years. Based on claimant's life expectancy, the present value of future medical care exceeds $8,810.41, which is the remaining balance of the proceeds from the third party settlement.

CONTENTIONS

The paying agency asserts entitlement to the remaining balance of the recovery as a reserve for anticipated future expenses. Relying upon the opinion of the treating physician, it contends that claimant will seek treatment approximately three times a year and will require daily doses of Feldene for the rest of his life. Based on claimant's life expentancy of 34.5 years, the agency submits that the present value of its reasonably to be expected future expenditures for claimant's future medical care exceeds the remaining balance of the third party settlement.

Claimant concedes that claimant will require "some" future prescriptions of Feldene. However, asserting that this medication is all that can be "reasonably expected in the future," he asks that the balance of the funds be distributed to him pursuant to ORS 656.593(3).

CONCLUSIONS

Following the distribution of costs, attorney fees, and the worker's 1/3 statutory share, the paying agency shall be paid and retain the balance of the recovery, but only to the extent that it is compensated for its expenditures for compensation, first aid or other medical, surgical or hospital service, and for the present value of its reasonably to be expected future expenditures for compensation and other costs of the worker's claim under ORS 656.001 to 656.794. ORS 656.593(1)(a),(b), and (c). Such other costs do not include any compensation which may become payable under ORS 656.273 or 656.278. ORS 656.593(1)(c).

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

To support its lien for anticipated future expenditures, the paying agency must establish that it is reasonably certain to incur such expenditures. Leonard Henderson, 40 Van Natta 31 (January 21, 1988); Robert T. Gerlach, 36 Van Natta 293, 297 (1984); Gerald Herrington, 35 Van Natta 859, 860 (1983); Leroy R. Schlecht, 32 Van Natta 261 (1981), rev'd in part on other grounds Schlecht v. SAIF, 60 Or App 449 (1982).

Following our review of this record, we conclude that the paying agency has established that it is reasonably certain it will incur future medical expenditures resulting from claimant's

compensable injury. In reaching this conclusion, we are persuaded by the opinion and reports offered by Dr. Schachner, claimant's treating physician. Schachner provides a thorough explanation of claimant's current condition and describes a future course of treatment.

This future treatment, which is based on the premise that claimant does not suffer an aggravation and continues to perform his current work activities, includes three routine examinations per year and a daily dosage of one Feldene tablet. Inasmuch as costs from future aggravation claims are not recoverable under the third party statutes and since the record suggests that claimant intends to continue performing his strenuous duties as a police officer, we consider these anticipated medical services to be reasonably certain.

We further conclude that the present value of the paying agency's reasonably to be expected future expenditures exceeds the remaining balance of the third party settlement. We base this conclusion upon the current charges for routine medical examinations and Feldene prescriptions, which persuasively establish that the annual costs for claimant's medical treatment is $772.55.

As previously noted, these charges do not reflect the costs attributable to future aggravation claims, which are not lienable pursuant to ORS 656.593(c). When claimant's life expentancy of 34.5 years is considered, the present value of claimant's medical expenditures attributable to his compensable condition exceeds $8,810.41, which is the remaining balance of the third party settlement.

Accordingly, we hold that the paying agency is entitled to a lien for the present value of its reasonably to be expected future expenditures for medical care resulting from claimant's compensable injury. We further conclude that the following distribution of the remaining proceeds from the third party settlement is just and proper. See ORS 656.593(3). Inasmuch as the paying agency's lien for future expenditures exceeds $8,810.41, which is the remaining balance of the proceeds from the third party settlement, claimant's attorney is directed to distribute the aforementioned sum to the paying agency.

IT IS SO ORDERED.

DENISE M. BOWMAN, Claimant
Welch, et al., Claimant's Attorneys
William Dickas, Defense Attorney

WCB 87-18040
April 25, 1988
Order Denying Motion to Dismiss

Claimant has moved the Board for an order dismissing the noncomplying employer's request for Board review on the ground that a copy of the request was not served on all parties. We deny the motion.

FINDINGS

The Referee's order issued March 1, 1988. On March 10, 1988, the employer's counsel mailed a request for Board review. The request did not include an acknowledgment of service or a certificate of personal service by mail upon claimant or any of the parties who

appeared at the hearing and their attorneys. See OAR 438-05-046(2)(b); 438-11-005(3). However, the request for review did indicate that a copy of the request had been provided to claimant's attorney.

Claimant's attorney received a copy of the request for review on March 11, 1988. On March 17, 1988, the Board mailed a computer-generated letter to all parties acknowledging the request.

CONCLUSIONS

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

"Party" means a claimant for compensation, the employer of the injured worker at the time of injury and the insurer, if any, of such employer. ORS 656.005(19). Attorneys are not included within the statutory definition of "party." Robert Casperson, 38 Van Natta 420, 421 (1986). Yet, in the absence of a showing of prejudice to a party, timely service of a request for Board review on the attorney for a party is adequate compliance with ORS 656.295(2) to vest jurisdiction in the Board. Argonaut Insurance v. King, supra, page 850-51; Nollen v. SAIF, 23 Or App 420, 423 (1975), rev den (1976); Robert C. Jaques, 39 Van Natta 299 (1987).

Here, no contention has been made that claimant has been prejudiced by not directly receiving a copy of the employer's request for review. Moreover, since the Board's acknowledgment letter was mailed to the parties 16 days after the Referee's order, we conclude that it is more probable than not that all parties to the hearing received actual notice of the employer's request for review within the statutory 30-day period. See John D. Francisco, 39 Van Natta 332 (1987); James L. Sampson, 37 Van Natta 1549, 1550 (1985).

Inasmuch we find that all parties to this proceeding received timely notice of the employer's request for review, we conclude that we have jurisdiction to consider the request for Board review. See ORS 656.295(2); Argonaut Insurance Co. v. King, supra; Nollen v. SAIF, supra.

Accordingly, claimant's motion to dismiss is denied. Upon the Board's receipt of the hearing transcript, copies will be provided to the parties. Thereafter, a briefing schedule shall be implemented.

IT IS SO ORDERED.

MARGRETTE M. BURRUSS, Claimant
Bischoff & Strooband, Claimant's Attorneys
SAIF Corp Legal, Defense Attorney

Own Motion 88-0098M
April 25, 1988
Own Motion Order

SAIF Corporation has submitted to the Board claimant's claim for an alleged worsening of her December 28, 1981 industrial injury. Claimant's aggravation rights have expired. SAIF opposes reopening of this claim as claimant's treatment was on a diagnostic basis and no surgery has been indicated.

Pursuant to ORS 656.278(1)(a), we may exercise our own motion authority when we find that there is a worsening of a compensable injury that requires either inpatient or outpatient surgery or other treatment requiring hospitalization. We note that claimant was hospitalized for diagnostic testing (myelogram) on December 30, 1987 and released the same day. Shortly thereafter, she developed headaches from the myelogram and was rehospitalized for a few days. Under these circumstances, claimant is entitled to temporary total disability compensation. However, there is no evidence that claimant had been gainfully employed prior to her alleged worsening. The only evidence provided to the Board indicates that she last worked sometime in 1985. Absent evidence to show she was either in the work force or looking for work, we are unwilling to reopen the claim for the payment of temporary total disability compensation. Cutright v. Weyerhaeuser Company, 299 Or 290 (1985), and Karr v. SAIF, 79 Or App 250 (1986). The request for own motion relief is hereby denied.

IT IS SO ORDERED.

CECILE R. DESMARAIS, Claimant
Doblie & Associates, Claimant's Attorneys
Mark Bronstein (SAIF), Defense Attorney

WCB 87-18580
April 25, 1988
Order of Dismissal

Claimant has requested review of Referee Knapp's order dated March 8, 1988. We have reviewed the request to determine whether we have jurisdiction to consider the matter. We conclude that we lack jurisdiction.

FINDINGS

Claimant's request was hand-delivered to the Board on April 8, 1988. The request included a certificate of personal service by mail upon the employer and its insurer.

The request for Board review was filed more than 30 days after the date of the Referee's order.

CONCLUSIONS

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

Here, the 30th day after the Referee's March 8, 1988 order was April 7, 1988. Claimant's request for Board review was filed April 8, 1988, 31 days after the date of the Referee's order. 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 v. King, supra.

Accordingly, the request for Board review is dismissed.

IT IS SO ORDERED.

ARLO W. DUNBAR, Claimant
Bick & Monte, Claimant's Attorneys
SAIF Corp Legal, Defense Attorneys

WCB TP-87017
April 25, 1988
Third Party Order

The SAIF Corporation, as paying agency, has petitioned the Board to resolve a dispute concerning the distribution of proceeds from a third party judgment. See ORS 656.593(1). In response, claimant asks that SAIF be required to approve a proposed settlement which disposes of two pending denied claims in return for SAIF's waiver of its third party lien.

FINDINGS

In October 1983 claimant was "injured while on the job when struck by a garbage dumpster being propelled toward him as a result of being hooked by the rear end of a truck." SAIF accepted his shoulder injury claim, but denied those portions of the claim concerning his back and leg. In March 1984, after returning to work, claimant fell. His aggravation and "new injury" claims for his back and leg conditions were denied. He requested a hearing concerning these claims.

Claimant initiated a cause of action against the operator and owner of the truck which had "hooked" the dumpster. In the summer of 1986, he obtained a judgment of $87,500, plus a $904.30 cost bill. His one-third attorney fee equalled $29,166.67 and his total litigation costs equalled $8,431.72. After providing for claimant's attorney fee, costs, and statutory 1/3 share pursuant to ORS 656.593(1)(b), the remaining balance is $33,870.61.

SAIF's lien for its claim costs attributable to claimant's compensable shoulder injury currently totals $39,973.50. This lien is composed of temporary disability compensation, medical services, and permanent disability benefits. Because its actual claim costs exceed its maximum distributive share from the remaining balance of the judgment, SAIF does not assert a lien for future expenditures.

Prior to an April 1987 hearing concerning claimant's denied back and leg claims, his attorney and SAIF's hearing's attorney and third party claims examiner tentatively agreed to a settlement of their disputes. In return for SAIF's waiver of its third party lien, claimant would agree to dismiss his pending hearing request as well as release any future claims for aggravation concerning his current symptoms.

Anticipating the formalization of the agreement, claimant cancelled the scheduled hearing. Despite the cancellation, the hearing request has not been dismissed and

currently remains pending. On the advice of its third party counsel, SAIF subsequently declined to finalize the proposed agreement. It was SAIF's counsel's conclusion that such an agreement was contrary to ORS 656.236(1), which prohibits the release of a claimant's workers' compensation rights.

CONTENTIONS

Claimant asserts that he has been aggrieved as a result of SAIF's refusal to finalize the agreement. Specifically, he contends that he has waived his right to a hearing concerning the denied claims and has incurred a substantial amount of attorney fees for his counsel's services rendered during the settlement negotiations. To remedy this situation, he requests that we direct SAIF to approve the settlement.

CONCLUSIONS

Under the Workers' Compensation Law, the Board is authorized to resolve disputes concerning third party matters. See ORS 656.576 et seq. However, this authority is reserved to several specific instances. These circumstances include: (1) the resolution of disputes concerning the paying agency's failure to approve a compromise between the worker and the third party (ORS 656.587); (2) the resolution of any conflict as to the amount of the balance of the recovery from the third party judgment to be retained by the paying agency (ORS 656.593(1)(d)); and (3) the resolution of any conflict as to what may be a just and proper distribution of the remaining proceeds from a third party settlement (ORS 656.593(3)).

Here, claimant is asking that we resolve a dispute concerning SAIF's failure to approve a compromise not between claimant and the third party, but rather, between claimant and SAIF. The power to grant such a request does not lie within our statutory authority. Moreover, as represented to us, aspects of the agreement are suggestive of a release of claimant's future workers' compensation rights. Since the purported release concerns the distribution of proceeds from a third party judgment and not a third party settlement, portions of the agreement would appear to be in violation of ORS 656.236. See Roger Riepe, 37 Van Natta 3, 7 (1985); William J. Hamilton, 36 Van Natta 576 (1984).

As SAIF concedes, the timing of its refusal was "unfortunate." Yet, as discussed above, the refusal was not without justification. Furthermore, as SAIF accurately represents, the hearing concerning the denied claims has not been dismissed, only postponed. Thus, claimant has not waived his right to contest the compensability of the denied claims.

Undoubtedly, a significant amount of legal services has been expended as these ill-fated negotiations proceeded. However, we are unaware of any authority which would allow for claimant's counsel's recovery of attorney fees for services rendered in negotiations of a settlement which was neither executed nor approved. We further note that 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 approved by a Referee, Board, or the Court of Appeals. See ORS 656.388(1); OAR 438-15-015. Therefore, claimant's counsel's fee for legal services rendered in this

matter is presently limited to his 1/3 share of the third party judgment. ORS 656.593(1)(a); OAR 438-15-095.

Inasmuch as we lack authority to grant claimant's request, we turn to SAIF's petition for distribution of the third party judgment. The statutory scheme for the allocation of damages is precise. Robert B. Williams, 38 Van Natta 119, 123 (1986), aff'd. Estate of Troy Vance v. Williams, 84 Or App 616 (1987). ORS 656.593(1) provides in detail exactly how, and in what order, the damages shall be distributed. As previously discussed, we are specifically authorized to resolve any conflict concerning the amount of the balance of the recovery which may be retained by the paying agency. See ORS 656.593(1)(d).

Here, SAIF's actual claim costs exceed the balance remaining after distribution of claimant's attorney fees, costs, and statutory 1/3 share. Because we find these costs attributable to compensation, first aid, or other medical, surgical or hospital service resulting from claimant's compensable shoulder injury claim, we conclude that SAIF is entitled to retain the remaining balance of the third party judgment. See ORS 656.593(1)(c)(d).

Finally, SAIF seeks an award of interest based upon its share of the proceeds. The third party statutes have not authorized the Board to grant such a request. See Gerald Herrington, 35 Van Natta 859, 862 (1983). Consequently, the request is denied.

Accordingly, the proceeds of the third party judgment shall be distributed in accordance with ORS 656.593(1). That is, claimant's attorney shall recover $29,166.67 in attorney fees and $8,431.72 in litigation costs. Claimant's attorney is directed to pay to claimant $16,935.30. Finally, claimant's attorney shall pay to the SAIF Corporation the remaining balance of the recovery, $33,870.61.

IT IS SO ORDERED.

JEANETTE L. HERROD, Claimant
Doblie & Associates, Claimant's Attorneys
Edward C. Olson, Defense Attorney

WCB 87-08338
April 25, 1988
Order on Review

Reviewed by Board Members Johnson and Ferris.

The insurer requests review of that portion of Referee Leahy's order that set aside its denial of compensability for claimant's back condition. On review, the issue is compensability. We affirm.

FINDINGS OF FACT

In 1983, claimant worked as a cook for 40 hours a week. This job involved only light to medium lifting. During this time period she began a second job with a janitorial service. On June 3, 1986, while working for the janitorial service, claimant had to lift three plastic bags of computer paper and carry them outside. She felt pain in her right shoulder and back as she lifted the third bag. She reported this incident to her employer.

On December 9, 1986 claimant filed a claim with the janitorial service. The insurer denied her claim on May 8, 1987.

Claimant's treating physicians were Dr. Shipp, chiropractor, and Dr. Markham, neurosurgeon. Dr. Shipp reported that claimant had received an unexpected trauma to her spine and diagnosed chronic severe lumbar segmental dysfunction with associated enthesopathy, and spondylolisthesis at L5-S1. Subsequently, he began a course of chiropractic adjustments. He also prescribed a lumbosacral corset, Williams flexion exercises and lumbar traction. The lifting claimant did while working for the janitorial service caused her vertebrae misalignment to become symptomatic.

CONCLUSIONS AND REASONING

The insurer contends that this claim is an occupational disease claim rather than an injury claim and, therefore, claimant has failed to carry her burden of proof.

The Referee analyzed this case as an injury claim and set aside the insurer's denial. He determined that claimant suffered an unexpected trauma to her spine on June 3, 1986 and found the medical and lay evidence presented by claimant to be persuasive. We agree.

Generally, injuries are caused by identifiable, discrete events, while a disease has a gradual onset and its existence is often not perceived until after the time of affliction. Crowe v. Jeld-wen, 77 Or App 81 (1985). In the present case, the incident on June 3, 1986 comprised a discrete episode which caused claimant's misaligned spine to become symptomatic thereby forming the basis for an injury claim. Accordingly, we agree with the Referee's analysis of this case as a claim for an injury, rather than one for an occupational disease.

Turning to the medical evidence, we consider the opinions of claimant's treating physician to be persuasive. Weiland v. SAIF, 64 Or App 810, 814 (1983). Claimant's treating physicians' reports support her contention that she suffered a compensable injury on June 3, 1986.

The treating physicians' reports were persuasive because they were well reasoned and consistent with the record as a whole. See Somers v. SAIF, 77 Or App 259 (1986). The reports indicate that: (1) claimant's low back was asymptomatic before June 3, 1986; (2) after the lifting episode claimant sought treatment to relieve the pain she was experiencing; (3) claimant suffered a chronic severe lumbar segmental dysfunction with associated enthesopathy, and spondylolisthesis; and (4) her June 3, 1986 injury caused her misaligned low back to become symptomatic.

The medical evidence establishes that claimant suffered a compensable injury. Consequently, we affirm the order of the Referee.

Although claimant's counsel is entitled to an insurer-paid fee for services rendered on Board review, we cannot authorize an insurer-paid attorney fee because no statement of services has been received to date. Therefore, an assessed fee shall not be authorized.

ORDER

The Referee's order dated December 10, 1987 is affirmed.

PETER G. JEBENS, Claimant
Cash Perrine, Claimant's Attorney
Schwabe, et al., Defense Attorneys

WCB 86-09843
April 25, 1988
Order on Reconsideration (Remanding)

Reviewed by Board Members Johnson and Ferris.

Claimant requested reconsideration of the Board's Order on Review dated November 27, 1987. The issue was the reasonableness and necessity of surgery proposed for claimant's low back. We abated our order to allow sufficient time to consider the request. On February 5, 1988, claimant filed a motion to remand the case to the Referee. Attached to the motion were reports which reveal that claimant underwent the proposed surgery on December 8, 1987. These reports were not available at the time of the hearing and are highly probative on the issue of the reasonableness and necessity of the surgery. After due consideration, we conclude that the case should be remanded to the Referee for further development. See Parmer v. Plaid Pantry #54, 76 Or App 405, 409 (1985).

IT IS SO ORDERED.

RAMEY S. JOHNSON, Claimant
Robert Chapman, Claimant's Attorney
Cowling & Heysell, Defense Attorneys

WCB 87-06194
April 25, 1988
Order of Dismissal

Claimant requested Board review of Referee Mongrain's February 26, 1988 order. Contending that the request for Board review was submitted in error and that further proceedings are necessary, claimant asks that this matter be returned to the Referee. The insurer opposes the remand request, asserting that claimant has requested Board review and that the parties have had an ample opportunity to present evidence.

We conclude that jurisdiction currently rests with the Referee. Therefore, the request for review is dismissed and this case is returned to the Referee.

FINDINGS

On March 7, 1988, claimant, pro se, requested Board review of Referee Mongrain's February 26, 1988 order. On March 21, 1988, the Board received a handwritten letter from claimant, asking that his request for review be withdrawn. The letter, which had been mailed by certified mail on March 18, 1988, further advised the Board that claimant's attorney would shortly be submitting "a request on [claimant's] behalf."

Also on March 21, 1988, claimant's attorney asked the Referee to abate and reconsider his order. In the motion for reconsideration, claimant's counsel asserted that the Referee had issued his order without receiving further medical evidence for which the record had previously been held open. In addition, claimant's counsel contended that the Referee had failed to address the insurer's motion to abate the proceedings. On March 24, 1988, "in order to allow an appropriate opportunity for consideration of counsel's motion and any response," Referee Mongrain abated his February 26, 1988 order.

CONCLUSIONS

A Referee's order is final unless, within 30 days after the date on which a copy of the order is mailed to the parties, one of the parties requests Board review under ORS 656.295. ORS 656.289(3). The time within which to appeal an order continues to run, unless the order has been "stayed," withdrawn, or modified. International Paper Co. v. Wright, 80 Or App 444 (1986); Fischer v. SAIF, 76 Or App 656, 659 (1986). In order to abate and allow reconsideration of an order issued under ORS 656.289(1), at the very least, the language of the second order must be specific. Farmers Insurance Group v. SAIF, 301 Or 612, 619 (1986).

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). Timely request for Board review is a jurisdictional prerequisite for our review. ORS 656.289(3); 656.295(2); Argonaut Insurance Co. v. King, 63 Or App 847, 852 (1983). Once the request for review is withdrawn, for whatever reason, where no other party has requested review in a timely manner, we no longer have jurisdiction to proceed. John K. Eder, 38 Van Natta 1372 (1986); aff'd Eder v. Pilcher Construction, 89 Or App 425 (February 10, 1988).

Here, we attained jurisdiction by virtue of the timely filing of claimant's request for review of the Referee's February 26, 1988 order. However, upon the filing of claimant's withdrawal of his request for review, we no longer had jurisdiction to consider this case. With the withdrawal of claimant's appeal, the Referee's February 26, 1988 order would become final 30 days after its issuance. ORS 656.289(3). Yet, on March 24, 1988, after jurisdiction left the Board, but prior to the expiration of the 30-day appeal period, the Referee expressly abated his February 26, 1988 order.

Inasmuch as the Referee abated his February 26, 1988 order while he had authority to do so, we hold that jurisdiction over this matter remains with the Referee. Consequently, this case shall be returned to the Referee for further consideration and the issuance of a final order.

Accordingly, claimant's request for Board review is dismissed. This case is remanded to Referee Mongrain for further proceedings consistent with his March 24, 1988 order.

IT IS SO ORDERED.

ALFRED LEGARDE, Claimant
Vick & Gutzler, Claimant's Attorneys
Roberts, et al., Defense Attorneys

WCB 87-16857
April 25, 1988
Order of Dismissal

The self-insured employer has moved the Board for an order dismissing claimant's request for review on the ground that neither it nor its representatives received timely notice of the request. The motion is granted.

FINDINGS

The Referee's order issued February 16, 1988. Claimant's request for review, dated March 12, 1988, was received by the Board on March 15, 1988. The request did not include an

acknowledgment of service or a certificate of personal service by mail upon either the employer, its claim administrator, or its attorney.

On March 17, 1988, the Board mailed a computer-generated letter to all parties acknowledging the request. The employer received a copy of this acknowledgment on March 21, 1988. The employer's counsel did not receive a copy of the acknowledgment. Neither the employer nor its representatives received a copy of the request for Board review.

We find that claimant's request for Board review was timely filed. However, we find that neither the employer nor its representatives were provided copies of the request for review, or received actual notice of the request, within 30 days of the Referee's order.

CONCLUSIONS

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

Here, the thirtieth day after the Referee's February 16, 1988 order was March 17, 1988. Thus, claimant's request for Board review, received by the Board on March 15, 1988, was timely filed. However, neither the employer nor its representatives were timely provided with, 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 v. King, supra.

We are mindful that claimant has apparently requested review without benefit of legal representation. We further realize that an unrepresented party is not expected to be familiar with administrative and procedural requirements of the Workers' Compensation Law. Yet, we are not free to relax a jurisdictional requirement, particularly in view of Argonaut Insurance Co. v. King, supra. See Nancy J. Schelin, 39 Van Natta 437 (1987); Alfred F. Puglisi, 39 Van Natta 310 (1987); Julio P. Lopez, 38 Van Natta 862 (1986).

Accordingly, the request for Board review is dismissed.

The employer's counsel seeks authorization of a client-paid fee to be paid by the employer for its counsel's services rendered before the Board. After reviewing the statement of services and attorney retainer agreement and considering the factors set forth in OAR 438-15-010(6), we approve a client-paid fee, not to exceed $104.

IT IS SO ORDERED.

The Beneficiaries of
WILMA F. MACAITIS (Deceased), Claimant
Quintin B. Estell, Claimant's Attorney
John Motley (SAIF), Defense Attorney

WCB 87-06841
April 25, 1988
Order of Dismissal

The Personal Representative for the estate of the deceased claimant requests review of Referee Basker's order that dismissed claimant's hearing request for a failure to appear at the hearing. Contending that a statutory beneficiary does not exist to continue claimant's claim for benefits, the SAIF Corporation has moved for the dismissal of the request for Board review. The motion is granted.

FINDINGS

In April 1987, claimant requested a hearing from a recently issued Determination Order. The hearing request raised the issues of medical services, premature claim closure, temporary total disability, and permanent disability. Later, the issue of permanent total disability was included. The hearing was eventually scheduled for February 9, 1988.

Approximately three weeks before the hearing date, claimant's attorney advised the Referee that claimant had died. Stating that time was needed to determine whether claimant had left any survivors, claimant's attorney requested postponement of the hearing. The request for a postponement was denied. Thereafter, the hearing was convened as previously scheduled. When neither claimant nor her counsel appeared at the hearing, the Referee dismissed the request for hearing.

The Referee's dismissal order issued February 16, 1988. Claimant's attorney timely requested Board review. Thereafter, claimant's attorney submitted a retainer agreement, designating the attorney to represent claimant's estate in these proceedings. The agreement was signed by the Personal Representative of claimant's estate.

At the time of her death, claimant was not married. She was also the mother of a son, who was at least 21 years of age and not living at home. Claimant left no dependents.

CONCLUSIONS

Survival of actions in workers' compensation cases is governed strictly by statute. See Majors v. SAIF, 3 Or App 505 (1970); Charlotte Kuklhanek, 37 Van Natta 1697, 1698 (1985). If the worker has filed a request for a hearing pursuant to ORS 656.283 and death occurs prior to the final disposition of the request, the persons described in ORS 656.218(5) shall be entitled to pursue the matter to final determination of all issues presented by the request for hearing. ORS 656.218(3).

The persons entitled to pursue the matter are those "who would have been entitled to receive death benefits if the injury causing the disability had been fatal." ORS 656.218(5). Death benefits are payable to the worker's surviving spouse, children under the age of 18 years, or the worker's "dependents." ORS 656.204(2), (4), and (5). Pursuant to ORS 656.005(10), "dependent" refers to a series of relatives of the deceased worker "who at the time of the accident, are dependent in whole or in part for their support upon the earnings of the worker."

Here, the record fails to establish that claimant was survived by an individual who meets any of the aforementioned definitions. Therefore, we conclude that no statutory beneficiary exists to continue claimant's claim for benefits as raised in her hearing request. Accordingly, the request for Board review is dismissed.

Claimant's attorney asks that this case be remanded to the Referee to permit the estate to collect a burial allowance. The request is denied.

Counsel is apparently relying on ORS 656.218(5), which provides that "[I]n the absence of persons [entitled to receive death benefits], a burial allowance may be paid not to exceed the lesser of either the unpaid award or the amount payable by ORS 656.204." ORS 656.204(1) states that if death results from the accidental injury, the cost of burial, including transportation of the body, shall be paid, not to exceed $3,000 in any case.

Claimant's estate may be entitled to a burial allowance pursuant to the aforementioned statutes. Yet, this issue was not raised at any time prior to the hearing or the Referee's order. Rather, the issues in this case, as set forth in claimant's hearing request and her counsel's correspondence, pertained to her entitlement to medical services, temporary disability, and permanent disability, partial and total.

In conclusion, the estate's entitlement to a burial allowance would appear to remain a viable issue if directed to the appropriate forum. However, because the issue is not properly before us, we decline to address it. Furthermore, since we conclude that the present case has not been improperly, incompletely or otherwise insufficiently developed, we find that remand is not appropriate. See ORS 656.295(5).

IT IS SO ORDERED.

MARTIN MANNING, Claimant
Roger D. Wallingford, Claimant's Attorney
Roberts, et al., Defense Attorneys
Schwabe, et al., Defense Attorneys

WCB 87-14815 & 87-13538
April 25, 1988
Order Dismissing Request for Board Review and Directing Republication of Referee's Order (Remanding)

Gates, McDonald & Co., the claims processing agent for North Clackamas School District, a self-insured employer, has requested Board review of Referee Menashe's order dated January 22, 1988. The Referee set aside Gates' denial of claimant's aggravation claim for his cervical and thoracic condition and upheld Kemper Insurance's denial of claimant's "new injury" claim for the same condition.

Gates concedes that its request for review is submitted more than 30 days after the date of the Referee's order. However, enclosing affidavits from its counsel and claimant's attorney, Gates contends that copies of the Referee's order were not mailed to all parties of interest to the proceeding. Consequently, Gates requests that this matter be returned to the Referee with directions to republish his order. The request is granted.

FINDINGS

In accordance with ORS 656.283(5), at least 10 days' prior notice of the time and place of the hearing was provided to all parties in interest by mail. Gates, as the self-insured employer's claims processing agent, received this notice as a party in interest.

The Referee's order purports to list all parties to the proceeding and their respective representatives. The order further states that copies were mailed to each of those listed. However, the list does not contain the full and accurate name of the employer's claims processing agent. Rather, the order identifies the processor as "McDonald." Moreover, no address for the employer's claims processor is set forth in the order. Finally, although the order refers to the employer's attorney's firm, the firm did not receive a copy of the order. Instead, claimant's attorney received two copies of the Referee's order.

After reviewing this record, in conjunction with the documents submitted by Gates' attorney, we find that at least one party in interest, Gates, did not receive a copy of the Referee's order.

CONCLUSIONS

"Party" means a claimant for compensation, the employer of the injured worker at the time of injury and the insurer, if any, of such employer. ORS 656.005(19). All notices of proceedings required to be sent under ORS 656.262, 656.265 to 656.330, 656.382 to 656.388 shall be sent to the employer and the insurer, if any. ORS 656.263.

A Referee's order shall be mailed to all parties in interest. ORS 656.289(2). If a Referee's order is not mailed to all parties, the order is not final and is not subject to Board review. ORS 656.289(2), (3); Armstrong v. SAIF, 65 Or App 809 (1983), after remand, 67 Or App 498 (1984); Robert E. Lundeen, 38 Van Natta 1388 (1986).

Here, the Referee's order was not mailed to Gates, the employer's claims processing agent. Although Gates is not an insurer, as the employer's processing agent, it stands as the functional equivalent of one. This conclusion is further supported by the fact that, through its receipt of a Notice of Hearing, Gates was considered to be a party in interest.

Under these circumstances, we conclude that the Referee's order was not mailed to a party in interest to the proceedings. Therefore, the order is neither final nor subject to our review. ORS 656.289(2), (3); Armstrong v. SAIF, supra; Robert E. Lundeen, supra. Accordingly, the request for review is dismissed as premature.

Accordingly, this matter is remanded to Referee Menashe with instructions to issue a republished and final order bearing a new date of actual mailing to all parties to this proceeding, including their respective representatives.

IT IS SO ORDERED.

JERRY R. MILLER, Claimant
Patrick Mackin, Claimant's Attorney
Nelson, et al., Defense Attorneys
Carroll Smith (SAIF), Defense Attorney

WCB 87-06381 & 87-10549
April 25, 1988
Order Dismissing Request for Board Review (Remanding)

On February 2, 1988, Liberty Northwest Insurance Corporation requested Board review of Referee Knudsen's February 1, 1988 "Order on Reconsideration." On February 16, 1988, claimant filed his cross-request for review of the Referee's February 1, 1988 order.

Claimant moves for dismissal of Liberty's request for review, asserting that neither himself, Liberty's insured, nor SAIF's insured was mailed a copy of Liberty's request for Board review. Contending that the Referee's order was not a final order, Liberty now asks that this case be remanded to the Hearings Division.

We hold that notice of Liberty's request for Board review was timely provided to all parties to this proceeding. However, since we conclude that the Referee's order was not a final order, the requests for review are dismissed and this case is remanded to the Hearings Division.

FINDINGS

The Referee issued an Opinion and Order on December 3, 1987. Pursuant to the Referee's order, claimant was granted permanent total disability effective the date of the hearing, whereas a Determination Order had awarded 15 percent (48 degrees) unscheduled permanent disability under his low back injury claim with Liberty. In addition, Liberty, rather than the SAIF Corporation, was found to be responsible for the permanent total disability award. Finally, claimant's attorney was awarded 15 percent of the increased compensation created by the Referee's order, not to exceed $1,500.

Shortly thereafter, claimant's attorney submitted an affidavit in support of his request for additional attorney fees and Liberty moved for reconsideration of the Referee's order. On December 24, 1987, the Referee issued an Order of Abatement. Pursuant to the abatement order, the case was "reopened" and the Referee's December 3, 1987 order was "suspended."

On February 1, 1988, the Referee issued an Order on Reconsideration, in which he discussed the arguments raised by Liberty. The Referee denied the motion for reconsideration. Other than denying Liberty's motion, the Referee's order contained no further directive. In addition, the Order on Reconsideration neither withdrew the Referee's abatement order nor adhered to, or republished, the December 3, 1987 order.

On February 2, 1988, Liberty's attorney requested Board review of the Referee's February 1, 1988 order. Accompanying the request was a certificate of service by mail, which indicated that copies had been provided to claimant's attorney, SAIF, and SAIF's counsel. Neither claimant, Liberty's insured, nor SAIF's insured were mailed a copy of Liberty's request for review. On February 5, 1988, the Board mailed a computer generated letter acknowledging the request for review to all parties to the proceeding.

CONCLUSIONS

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

"Party" means a claimant for compensation, the employer of the injured worker at the time of injury and the insurer, if any, of such employer. ORS 656.005(19). Attorneys are not included within the statutory definition of "party." Robert Casperson, 38 Van Natta 420, 421 (1986). Yet, in the absence of a showing of prejudice to a party, timely service of a request for Board review on the attorney for a party is adequate compliance with ORS 656.295(2) to vest jurisdiction in the Board. Argonaut Insurance v. King, supra, page 850-51; Nollen v. SAIF, 23 Or App 420, 423 (1975), rev den (1976); Robert C. Jaques, 39 Van Natta 299 (1987).

Here, neither claimant nor SAIF's insured contends that they have been prejudiced by not receiving personal notice of Liberty's request for review. Moreover, since the Board's acknowledgment letter was mailed to the parties only four days after the Referee's order, we conclude that it is more probable than not that the parties received actual notice of Liberty's request for review within the statutory 30-day period. See John D. Francisco, 39 Van Natta 332 (1987); James L. Sampson, 37 Van Natta 1549, 1550 (1985). Consequently, we conclude that all parties to this proceeding received timely notice of Liberty's request for review.

We turn to the question of whether the Referee's February 1, 1988 order was a final, appealable order.

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 December 3, 1987 order fixed the amount of claimant's compensation, as well as the insurer that was responsible for the payment of that compensation. Thus, the Referee's initial order met the aforementioned definition for a final order. Yet, the Referee's December 3, 1987 order was "suspended" by virtue of the December 24, 1987 abatement order. Consequently, upon the issuance of the abatement order, the December 3, 1987 order no longer qualified as a final order.

The Referee's February 1, 1988 Order on Reconsideration neither finally disposed of, nor allowed a claim. Moreover, the order did not fix the amount of claimant's compensation. Finally, the February 1, 1988 order neither withdrew the December 24, 1987 abatement order nor adhered to, or republished, the December 3, 1987 order. Instead, the order merely denied Liberty's motion for reconsideration.

Inasmuch as further action before the Hearings Division is required as a result of the Referee's February 1, 1988 Order on Reconsideration, we conclude that it is not a final appealable order. Price v. SAIF, supra; Lindamood v. SAIF, supra. Consequently, we lack jurisdiction to consider the issues raised by the requests for Board review.

Accordingly, the requests for Board review are dismissed. We note that the Referee who issued this order is no longer employed by the Board. Therefore, this case is remanded to Referee Lipton, the Presiding Referee for the Board's Portland office, with instructions to issue a final appealable order.

IT IS SO ORDERED.

MICHAEL MORGAN, Claimant
Emmons, et al., Claimant's Attorneys
Merrily McCabe (SAIF), Defense Attorney

WCB 87-07167, 87-13050 & 87-15253
April 25, 1988
Order of Dismissal (Remanding)

The SAIF Corporation has requested Board review of Referee Hayduke's March 10, 1988 order. We have reviewed the request to determine whether we have jurisdiction to consider it. We conclude that the request is premature.

FINDINGS

SAIF's request was filed on April 11, 1988. Inasmuch as April 9, 1988 and April 10, 1988 fell on a Saturday and Sunday, we find that the request was timely filed. See ORS 174.120. However, on April 8, 1988, in response to SAIF's motion for reconsideration, Presiding Referee Daughtry had issued an Order of Abatement.

CONCLUSIONS

Since the Referee's March 10, 1988 order had been abated prior to the filing of SAIF's request for Board review, we lack jurisdiction to consider the issues raised in SAIF's request. Accordingly, the request for Board review is dismissed as premature. This matter is remanded to Presiding Referee Daughtry for further action.

IT IS SO ORDERED.

PENNY L. NICKLE, Claimant
Francesconi & Associates, Claimant's Attorneys
Scheminske & Lyons, Defense Attorneys

WCB 87-09156
April 25, 1988
Order on Review

Reviewed by Board Members Johnson and Ferris.

The insurer requests review of Referee Bennett's order that awarded claimant an additional 10 percent (32 degrees) unscheduled permanent disability for a back condition, beyond a Determination Order's prior award of 15 percent (48 degrees).

ISSUE

The extent of claimant's unscheduled permanent disability.

FINDINGS OF FACT

Claimant, 32 at hearing, began to experience back pain in July 1985, while working as a warehouse manager. She had no history of prior back difficulties. Her warehouse duties required frequent heavy lifting. In September 1985, she was taken off work by Dr. Duewel, her initial treating physician. She filed a claim for a back strain in October 1985, which was accepted by the insurer. The following month, she returned to work as an office receptionist. After approximately six weeks, she was unable to continue working as a receptionist due to increased back pain.

The Orthopaedic Consultants examined claimant in March and September 1986. The Consultants felt that claimant's continuing complaints were due to an inflammatory condition. In June 1986, claimant began treating with Dr. Griffin, rheumatologist. Griffin reexamined claimant in October 1986, and opined that her inflammatory condition had been controlled.

Later that month, the insurer issued a partial denial of a "concurrent inflammatory process." The partial denial was not appealed.

In December 1986, claimant was released to light work by Griffin. Thereafter, she began treating with Dr. Mullins, chiropractor.

Claimant has a GED certificate. Her prior jobs included pickup and delivery for Greyhound Package Express, preparing meals in a flight kitchen for American Airlines, delivering and servicing vending machines, and driving a school bus. At the time of hearing, she was employed as a bus driver. Her present physical restrictions prevent her from uninterrupted sitting, standing, or walking for more than one hour. She also should not lift in excess 25 pounds. Her degree of permanent physical impairment is mild.

Claimant's present off-the-job activities include periodically lifting bales of hay weighing up to 80 pounds, carrying wood into her house three times a week, and riding her horse eight to ten times a year.

Claimant's inflammatory condition resolved in October 1986. Her present complaints and permanent physical impairment are due to her compensable July 1985 low back strain.

CONCLUSIONS OF LAW

The criteria for rating the extent of claimant's unscheduled permanent disability is the permanent loss of earning capacity due to the compensable injury. ORS 656.214(5). To determine claimant's permanent loss of earning capacity, we consider her physical impairment as reflected in the medical record, the testimony at the hearing, and all of the relevant social and vocational factors set forth in OAR 436-30-380 et seq. We apply these rules as guidelines, not as restrictive mechanical formulas. See Harwell v. Argonaut Insurance, 296 Or 505, 510 (1984).

Here, the medical experts have rendered conflicting opinions concerning claimant's work-related physical impairment.

In September 1986, the Orthopaedic Consultants opined that claimant's injury-related residuals had resolved with no permanent impairment. According to the Consultants, claimant's continuing complaints were entirely due to a non work-related inflammatory condition. Considering the inflammatory condition, the Consultants recommended that claimant seek "lighter work" and not return to her former warehouse job.

On the other hand, in October 1986 Dr. Griffin found that claimant's inflammatory condition had been "completely controlled." Griffin felt that claimant's injury related permanent impairment was "mild." In April 1987, claimant was reexamined by Dr. Mullins. Mullins did not diagnose any inflammatory condition. According to Mullins, claimant's permanent impairment was "mild." In October 1987, Mullins recommended that claimant avoid uninterrupted sitting, standing, or walking for more than one hour, and lifting in excess of 25 pounds.

Absent persuasive reasons to do otherwise, we generally accord greater weight to the treating physician's opinion. McClendon v. Nabisco Brands, Inc., 77 Or App 412, 416 (1986); Weiland v. SAIF, 64 Or App 810 (1983). Given Griffin's and, in particular, Mullins' opportunity to observe claimant on numerous occasions, we are more persuaded by their assessment of claimant's physical restrictions and permanent impairment.

Claimant's mild permanent impairment prevents her from returning to her warehouse job, which required frequent heavy lifting. Her permanent impairment also limits her ability to perform lighter work, inasmuch as she was unable to work as a receptionist. Lastly, her high school education and lack of training further limit her ability to work in lighter occupations.

Accordingly, after our de novo review of the medical evidence and lay testimony, we agree with the Referee that a total award of 25 percent unscheduled permanent disability appropriately compensates claimant for her loss of earning capactity.

Claimant's counsel is statutorily entitled to a reasonable, carrier-paid attorney fee for services rendered on Board review. ORS 656.382(2). Such a fee is defined as an "assessed fee." OAR 438-15-005(2). However, we cannot authorize an assessed fee unless claimant's counsel files an executed attorney retainer agreement and a statement of services. OAR 438-15-010(1) & (5). Because no statement of services has been received to date, an assessed fee shall not be authorized.

ORDER

The Referee's order dated June 4, 1987 is affirmed. The Board approves the insurer's counsel's requested client-paid fee for services on review, not to exceed $1,366.50.

MICHAEL SOCIA, Claimant
Hayner, et al., Claimant's Attorneys
SAIF Corp Legal, Defense Attorney

Own Motion 88-0145M
April 25, 1988
Own Motion Order

SAIF Corporation has submitted to the Board claimant's claim for an alleged worsening of his October 25, 1973 industrial injury. Claimant's aggravation rights have expired. SAIF authorized the surgery performed on March 8, 1988, but opposes claim reopening on the basis that claimant is out of the work force.

Surgery was done on March 8, 1988 and the Board can reopen the claim on his own motion pursuant to ORS 656.278. However, consideration must be given to claimant's work history. Cutright v. Weyerhaeuser Company, 299 Or 290 (1985), and Karr v. SAIF, 79 Or App 250 (1986). SAIF contends claimant has not worked since about 1985. Claimant contends he has done part time work since 1985, including picking mushrooms, cutting wood, hauling trash and performing any other odd jobs he could find. In April or May 1987 claimant was given custody of his young son and chose to live on Aid to Dependent Children. The evidence indicates that claimant removed himself from the work force at that time. We conclude claimant is not entitled to compensation for temporary total disability during recovery from surgery. The request for own motion relief is hereby denied.

IT IS SO ORDERED.

RAYMOND STEINER, Claimant
Goldberg & Mechanic, Claimant's Attorneys
SAIF Corp Legal, Defense Attorney
James E. Griffin, Assistant Attorney General

WCB TP-87024
April 25, 1988
Third Party Order

The SAIF Corporation, as paying agency, has petitioned the Board for resolution of a dispute concerning the proper distribution of the proceeds of a third party settlement. See ORS 656.593(3). SAIF seeks an order directing that it receive an amount equal to the balance of claimant's recovery remaining after his attorney fees, costs, and statutory share are deducted from his third party settlement.

FINDINGS

SAIF's denial of claimant's occupational disease claim for chronic toxic encephalopathy was set aside by a Referee's order. The Board affirmed this order on July 21, 1987. SAIF's appeal from the Board's order is currently pending before the Court of Appeals.

Claimant initiated a cause of action against a third party. With SAIF's approval, the action was settled for $138,800. After deducting claimant's attorney fees, litigation expenses, and his 1/3 statutory share, the remaining balance of the third party recovery equals $57,511.33. SAIF's claimed lien is $127,099.34, composed of $43,926.04 in actual costs and $83,173.30 in projected future expenditures.

CONCLUSIONS

If a worker receives a compensable injury due to the negligence or wrong of a third person not in the same employ, the worker shall elect whether to recover damages from such third person. ORS 656.578. The proceeds of any damages recovered from a third person by the worker shall be subject to a lien of the paying agency for its share of the proceeds. ORS 656.593.

Inasmuch as SAIF is presently continuing to contest the compensability of his workers' compensation claim, claimant contends that SAIF's request is premature. We agree.

By virtue of a Referee and Board order, claimant's occupational disease claim is presently considered compensable.

Yet, since SAIF has appealed these decisions, neither order has become final. See ORS 656.289(3); 656.295(8). Consequently, the compensability of the claim has not been conclusively determined. Because compensability remains at issue, we are currently unwilling to order the distribution of proceeds to SAIF pursuant to the third party statutes.

At a minimum, SAIF asserts that we have authority to direct a partial distribution of proceeds equal to its actual costs incurred to date. In support of its contention, SAIF cites George Bedsaul, 35 Van Natta 695 (1983), where the Board directed that a paying agency be reimbursed from a settlement for temporary total disability and medical expenses. The Board further ordered that the remaining balance of the third party recovery be retained until such time as the issue of permanent disability had been finally determined.

We find Bedsaul distinguishable. In Bedsaul and other Board cases in which a partial distribution has been ordered, See John T. Elicker, 40 Van Natta 68 (February 19, 1988), John J. O'Halloran, 34 Van Natta 1504 (1982) and Robert B. Williams, 37 Van Natta 711 (1985), the claim's compensability was not at issue. There was no question that the insurer was entitled to a paying agency's lien under the third party statutes. Instead, the issues involved the size and dimension of the paying agency's lien.

Here, compensability of the claim remains a viable issue. Thus, it is unclear what proceeds from claimant's settlement will eventually be subject to third party distribution provisions. Because this aspect of the distribution issue would be rendered moot by a final determination of compensability, we defer consideration of the issue until the appellate process has been completed.

Finally, SAIF asks that it be awarded interest on any sum which claimant is directed to repay. Even if SAIF were to have received a portion of the proceeds, the third party statutes have not authorized the Board to grant such a request. See Gerald Herrington, 35 Van Natta 859, 862 (1983). This rationale applies equally to claimant's request for an additional attorney fee award.

Accordingly, claimant's attorney is ordered to hold in trust the balance of the third party settlement remaining after deduction of his attorney fees, litigation expenses, and statutory one-third share. If the claim is finally determined to be compensable, claimant's attorney is ordered to disburse the remaining balance in accordance with ORS 656.593(c), and (d). Any conflict concerning this distribution should be presented to the Board for resolution. In the event the claim is finally determined to be not compensable, the parties are directed to advise the Board of the court's decision and their respective positions on how the decision affects SAIF's entitlement to reimbursement of its claim costs under the third party statutes.

IT IS SO ORDERED.

THOMAS E. STEELE, Claimant
Bennett, Hartman, et al., Claimant's Attorneys
Alice M. Bartelt, Defense Attorney

WCB 86-09755
April 25, 1988
Order on Review

Reviewed by Board Members Johnson and Ferris.

Claimant requests review of Referee Quillinan's order which increased his award of unscheduled permanent disability for a back injury from 15 percent (48 degrees), as awarded by a Determination Order, to 25 percent (80 degrees). On review, the sole issue is extent of unscheduled disability. We affirm.

FINDINGS OF FACT

On June 30, 1984, claimant injured his back while working in an aluminum mill. Initially he was treated by the plant physician. Later, claimant's treating physician, Dr. Buxman, referred him to an orthopedic surgeon. All three doctors diagnosed a lumbar and renal contusion. Claimant was treated conservatively.

On December 27, 1984, Dr. Buxman found claimant medically stationary. He indicated claimant could not go back to heavy labor. In April 1986, Dr. Buxman reported claimant's physical limitations as occasional lifting between 11 and 50 pounds. He also indicated claimant should not carry over 25 pounds.

A January 1985 Determination Order granted claimant 15 percent unscheduled disability. A second Determination Order was issued in July 1986, with no change in permanent disability.

Upon completion of an authorized training program in upholstery, claimant opened his own shop. He currently works 20-25 hours per week and earns $400 a month. Claimant worked with his at-injury employer for approximately six years and earned $14.50 an hour.

Claimant suffers continuing and intermittent back symptoms. These include stiffness and discomfort with prolonged standing, bending and stooping. He has begun additional physical therapy under the care of a chiropractor.

At the time of hearing, claimant was 29 years of age. He has a high school education. Claimant's employment history includes building and repair, truck driving and small parts assembly. He is currently self-employed as a furniture upholsterer. Claimant cannot return to heavy labor but is capable of work in the moderate category. He has the physical capacity to work more than 20-25 hours per week.

CONCLUSIONS OF LAW AND OPINION

The criteria for rating the extent of claimant's unscheduled permanent disability is the permanent loss of earning capacity due to the compensable injury. ORS 656.214(5). To determine claimant's permanent loss of earning capacity, we consider her physical impairment as reflected in the medical record, 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, 296 Or 505, 510 (1984).

Claimant contends that the Referee's award of an additional 10 percent permanent disability does not adequately compensate him for his permanent loss of earning capacity. We disagree.

Claimant is self-employed and earns approximately $5 an hour. His restrictions preclude him from returning to heavy labor at which he earned approximately three times as much an hour.

A worker's post-injury earnings can be evidence of a loss of earning capacity. Claimant has suffered a reduction in wages as a result of his industrial injury. However, he has the physical capacity to work more hours at his current job. Moreover, he has skills to perform other remunerative work.

Therefore, we find that the Referee's award of an additional 10 percent permanent disability adequately compensates claimant for his loss of earning capacity.

ORDER

The Referee's order dated April 28, 1987 is affirmed.

RICHARD F. TAYLOR, Claimant
Peter O. Hansen, Claimant's Attorney
Nelson, et al., Defense Attorney
SAIF Corp Legal, Defense Attorney

WCB 87-11524 & 87-14282
April 25, 1988
Order Dismissing Request for Board Review and Directing Republication of Referee's Order (Remanding)

Liberty Northwest Insurance Corporation has requested Board review of the Referee's Order on Reconsideration dated January 28, 1988, which, following a December 23, 1987 abatement order, had adhered to the Referee's Opinion and Order dated December 9, 1987. The Referee set aside Liberty's denial of claimant's aggravation claim for his back condition and, implicitly, upheld the SAIF Corporation's denial of claimant's medical services claim for the same condition.

Counsels for Liberty and claimant have advised the Board that neither SAIF nor its attorney were mailed a copy of the Referee's orders. Consequently, they request that the Referee be directed to republish a final order, mailing copies to all parties to the proceeding. We grant the request.

FINDINGS

None of the Referee's orders indicate that a copy was mailed to SAIF or its attorney. After reviewing this record, in conjunction with the documents submitted by the attorneys for Liberty and claimant, we find that SAIF, a statutory party to these proceedings, was never mailed a copy of the Referee's orders.

CONCLUSIONS

Since the orders were not mailed to all parties, they are not final and are not subject to our review. ORS 656.289(2), (3); Armstrong v. SAIF, 65 Or App 809 (1983), after remand, 67 Or App 498 (1984); Robert E. Lundeen, 38 Van Natta 1388 (1986). Inasmuch as the Referee's orders are not final, Liberty's request for Board review is premature. Accordingly, the request for review is dismissed.

We note that the Referee who issued these orders is no longer employed by the Board. Therefore, this matter is referred to the Presiding Referee with instructions to issue a republished and final order bearing a new date of actual mailing to all parties to this proceeding, including their respective representatives.

IT IS SO ORDERED.

MICHAEL WHITTAKER, Claimant
SAIF Corp Legal, Defense Attorney

Own Motion 88-0163M
April 25, 1988
Own Motion Order

SAIF Corporation has submitted to the Board claimant's claim for an alleged worsening of his April 18, 1977 industrial injury. Claimant's aggravation rights have expired. SAIF opposes claim reopening as it contends claimant has removed himself from the work force.

Claimant underwent surgery on March 23, 1988 which has been accepted by SAIF. SAIF advised the Board that it had no evidence of claimant's recent work history and also advised claimant that he could send in other materials to the Board for consideration. Claimant has not taken advantage of the opportunity to submit proof of any recent employment. We can only conclude, on this record, that he has not been gainfully employed and, therefore, is not entitled to compensation for temporary total disability during recovery from surgery. Cutright v. Weyerhaeuser Company, 299 Or 290 (1985), and Karr v. SAIF, 79 Or App 250 (1986). The request for own motion relief is hereby denied.

IT IS SO ORDERED.

CATHERINE WILKERSON, Claimant
Michael B. Dye, Claimant's Attorney
Rick Barber (SAIF), Defense Attorney

WCB 85-01964
April 25, 1988
Order on Remand

This matter is before the Board on remand from the Court of Appeals. Wilkerson v. Davila, 88 Or App 298 (1987). The court reversed the Board's order in Catherine Wilkerson (WCB 85-01964), which affirmed the Referee's finding that: (1) claimant's compensable injury was not a material contributing cause of her psychiatric condition; and (2) claimant was not entitled to an additional award of unscheduled permanent disability for her back condition, beyond a Determination Order's previous award of 30 percent (96 degrees). Inasmuch as the Board did not consider claimant's psychiatric condition in rating the extent of her unscheduled permanent disability, the court remanded for a determination of that issue.

ISSUES

1. Whether the instant matter should be remanded to the Hearings Division.

2. The extent of claimant's unscheduled permanent disablity.

FINDINGS OF FACT

At the hearing, claimant took the position that her unscheduled permanent disability was due to both physical and psychiatric conditions. She, as well as her husband, testified regarding her extent of disability. Expert psychiatric and psychological reports were admitted into evidence.

Claimant is 54 years of age. She is educated through the ninth grade and has worked primarily as a waitress. She has no other training or experience. She cannot lift in excess of 10 pounds nor bend, stoop, or twist. Her physical restrictions prevent her from returning to her former type of work.

In addition, claimant's psychiatric condition has reduced her overall intellectual functioning. She has a reduced attention span, poor verbal recall, and a mild degree of aphasia.

CONCLUSIONS OF LAW

1. Whether remand is appropriate.

Claimant has requested that the Board remand this case to the Hearings Division so that the record regarding her pyschiatric condition may be fully developed. We decline to grant claimant's request.

We may remand to the Referee should we find that the record has been "improperly, incompletely or otherwise insufficiently developed." ORS 656.295(5). Here, claimant and her husband testified concerning her extent of disability and expert medical opinion concerning her psychiatric condition was admitted into evidence. Under such circumstances, we conclude that the record is properly, completely, and sufficiently developed.

2. The extent of claimant's disability.

In rating the extent of claimant's unscheduled permanent disability, we consider her loss of earning capacity and physical impairment attributable to the compensable injury, and all of the relevant social and vocational factors set forth in OAR 436-30-380 et seq. We apply these rules as guidelines, not as restrictive mechanical formulas. Harwell v. Argonaut Insurance Co., 296 Or 505, 510 (1984); Fraijo v. Fred N. Bay News Co., 59 Or App 260 (1982).

Following our review of the medical and lay evidence, and considering claimant's physical impairment, advanced age, limited education and work experience, decreased adaptability to lighter occupations, reduced mental capacity, and emotional and psychological condition, we conclude that an award of 50 percent unscheduled permanent disability appropriately compensates claimant for her compensable injury.

ORDER

Claimant is awarded an additional 20 percent (64 degrees) unscheduled permanent disability, for a total award to date of 50 percent (160 degrees). Her attorney is awarded an approved fee of 25 percent of this increased compensation. The attorney fee award shall be payable out of claimant's compensation.

STANLEY WILSON, Claimant
Coons & Cole, Claimant's Attorneys
Lester Huntsinger (SAIF), Defense Attorney

WCB 87-10010
April 25, 1988
Second Order of Dismissal

Claimant has requested reconsideration of our Order of Dismissal dated February 19, 1988. Concluding that we lacked jurisdiction, we dismissed claimant's request for review from a Referee's order which concerned a request for hearing from a Director's proposed order. Claimant contends that the Board has jurisdiction to consider those portions of the Referee's order which assessed penalties and attorney fees for the SAIF Corporation's alleged unreasonable failure to comply with the Director's proposed order. To allow sufficient time to consider the motion, we abated our order and granted SAIF an opportunity to respond. Having received SAIF's response, we have completed our further consideration of this matter. Consequently, our prior orders are withdrawn and replaced by the following order.

FINDINGS

In December 1973 claimant sustained a compensable injury. By virtue of an October 1974 Determination Order, he was granted permanent total disability. In 1986 a dispute arose concerning claimant's home health care services which were being provided by Laura Schaaf, registered nurse. In November 1986 SAIF denied responsibility for Schaaf's billings. Claimant requested a hearing.

The hearing request was subsequently dismissed in accordance with a March 1987 Stipulation and Order. Pursuant to the stipulation, SAIF rescinded its denial and agreed that Schaaf's services were reasonable, necessary, and related to claimant's compensable injury. The parties further stipulated that the amount of reimbursement for Schaaf's services would be determined by the Director of the Workers' Compensation Department.

Thereafter, the Medical Director of the Workers' Compensation Department performed an investigation and determined that reasonable compensation for Schaaf's services would be $3,000 per month. In May 1987 the Director of the Workers' Compensation Department issued a "Proposed And Final Order" directing SAIF to pay Schaaf $3,000 a month beginning in January 1986 and continuing as long as Schaaf rendered the same services to claimant. The order further advised the parties of their rights to request a hearing before the Hearings Division of the Board. SAIF timely requested a hearing. In response, claimant raised the issue of penalties and associated attorney fees for SAIF's alleged unreasonable failure to timely or fully comply with the Director's Proposed Order.

CONCLUSIONS

The Referee found that a fair rate of compensation for Schaaf's services was $1,500 a month. In addition, the Referee assessed a 10 percent penalty and $350 attorney fee against the "amounts unpaid under the [Director's] Order." Claimant requested Board review.

SAIF contends that upon its issuance, the Referee's order became the final order of the Director. As such, SAIF asserts that review of the order is only available pursuant to the

Administrative Procedures Act, ORS 183.310 to ORS 183.550. In support of these contentions, SAIF relies on the Department's administrative rules concerning medical service fee disputes. Following our review of this matter, we agree with SAIF's argument.

In the event of a dispute about fees between the vendor of medical services and the insurer, either may appeal to the Medical Director. OAR 436-10-090(6)(a). The Medical Director will investigate and advise the Director, who may issue an order advising either party to comply. id. Regardless of the Medical Director's decision, the injured worker is not liable for payment for any services for the treatment of the compensable injury or illness. OAR 436-10-090(5). Upon issuance of the Medical Director's order, either party may request a hearing pursuant to OAR 436-10-110(5). OAR 436-10-090(6)(a).

Pursuant to OAR 436-10-110(5), a hearing relating to a Director's proposed order shall be held by a Referee of the Hearings Division. Judicial review of the proposed order shall be as provided in ORS 183.310 to 183.550, except that the order of the Referee shall be a final order of the Director. OAR 436-10-110(5)(a). Any person adversely affected or aggrieved by an order of an agency is entitled to judicial review of a final order. ORS 183.480(1). Jurisdiction for judicial review of a contested cases concerning final orders of agencies is conferred upon the Court of Appeals. ORS 183.480(2); 183.482(1).

Here, the parties had previously agreed to submit their medical service fee dispute to the Director. Upon submission of this dispute to the Director, the processing of the matter became subject to the procedural framework set forth in OAR 436-10-090(6)(a) and OAR 436-10-110(5). That is, the parties could request a hearing from the Director's Proposed Order. Yet, upon its issuance, the Referee's order became the Director's final order and, as such, review was available directly to the Court of Appeals and not the Board. See OAR 436-10-110(5)(a).

Claimant contends that the Board retains jurisdiction over that portion of the Referee's order which pertains to the assessment of penalties and attorney fees. We disagree.

The issue of whether SAIF unreasonably failed to timely and fully comply with the Director's Proposed Order is inextricably entwined to the merits of the medical service fee dispute. As previously discussed, following the issuance of the Referee's order, jurisdiction to consider that dispute rests with the Court of Appeals. ORS 183.480(1), and (2); 183.482(1); OAR 436-10-110(5)(a). Claimant has neither cited, nor have we found, authority that would allow for, in effect, a bifurcation of the appellate process. We consider such a proposition patently inefficient and contrary to the procedures described by the aforementioned statutes and administrative rules.

Inasmuch as we lack jurisdiction to review the Referee's order, the request for review is dismissed. It is regrettable if the statement concerning the parties' rights of appeal contained in the Referee's order misled claimant. However, our jurisdiction is statutory and incorrect statements of appeal rights cannot expand or contract that jurisdiction. See Gary O. Soderstrom, 35 Van Natta 1710 (1983).

IT IS SO ORDERED.

CURTIS BROWN, Claimant
Beers & Zimmerman, Defense Attorneys

WCB 86-04530
April 27, 1988
Order on Review

Reviewed by Board Members Ferris and Crider.

Claimant, pro se, requests review of Referee Neal's order that affirmed a Determination Order which did not award unscheduled permanent disability for a neck injury. The issue is permanent disability. We affirm the Referee's order.

FINDINGS OF FACT

Claimant, 38 years old at the time of hearing, worked as a driver of a van when he injured his neck in a motor vehicle accident on November 14, 1983. Claimant did not return to work after that date. His claim was accepted by the insurer as a nondisabling injury.

Claimant was seen by Dr. Waldram, orthopedist, one week following the accident. Dr. Waldram diagnosed cervical strain. Subsequent x-rays revealed some straightening of claimant's cervical spine suggestive of spasm.

Believing that claimant was capable of returning to regular work, Dr. Waldram refused to assist claimant in obtaining welfare. Claimant subsequently transferred his care to Kaiser Permanente where he was examined by a number of physicians. Dr. Martin was unable to authorize time loss on the basis of his findings. Dr. Tilson, orthopedist, found no evidence of orthopedic or neurological deficits. He recommended job sheltering for 60 to 90 days. Dr. Duckler released claimant to regular work with no rating for permanent impairment.

Claimant did not seek medical treatment for the next year-and-a-half. During this time, he was examined by the Orthopaedic Consultants who found no neurological or orthopedic abnormalities. Finding no permanent impairment, they stated that claimant could return to work without restrictions.

Following the accident, claimant considered himself unable to handle the lifting duties inherent in his pre-injury job. The only work claimant has performed since the accident is occasional painting or light-cleaning jobs.

Claimant's claim was closed by an April 1, 1985 Determination Order that granted claimant temporary total disability compensation, less time worked, from January 28, 1984 through February 19, 1984. The order made no award of permanent disability.

In November 1985, claimant began treating with Dr. Danis, chiropractor. Dr. Danis noted a marked straightening of claimant's cervical spine. He commenced treating claimant with chiropractic manipulation and physiotherapy. As of the hearing, claimant was treating with Dr. Danis once every six to seven weeks.

After our de novo review of the record, we are not persuaded that claimant has experienced any permanent impairment as a result of his compensable injury.

CONCLUSIONS OF LAW AND OPINION

It is claimant's burden to prove that he has incurred a permanent loss of earning capacity as a result of the November 14, 1983 accident. ORS 656.214(5); Hutcheson v. Weyerhaeuser Co., 288 Or 51, 56 (1979). A finding of permanent impairment is a condition precedent to an award of permanent disability. See OAR 436-30-380.

Claimant's initial treating physician, Dr. Waldram, and his physicians at Kaiser all opined that claimant was capable of returning to his regular work. Dr. Duckler expressly noted an absence of permanent impairment. Only Dr. Danis and Dr. Bussanich, a consulting chiropractor, opined that claimant exhibited evidence of permanent impairment. However, they did not examine claimant until more than two years following the accident. Considering this lapse of time and the persuasiveness of the contrary medical opinions, we choose not to follow the conclusions of Drs. Danis and Bussanich.

In light of the fact that claimant underwent no treatment for an extended period of time, medical evidence of the nature and degree of claimant's continuing complaints prior to commencing treatment with Dr. Danis is lacking. We are aware that medical evidence is not statutorily required to establish the extent of permanent disability. Garbutt v. SAIF, 297 Or 148 (1984). We further note that claimant testified to continuing significant complaints. However, the Referee impliedly found claimant to be an unreliable witness based, in part, upon his demeanor at hearing. Considering the Referee's opportunity to observe a witness, we generally defer to the Referee's determination of credibility and reliability. Timothy J. Swodeck, 39 Van Natta 341 (1987).

In view of the relative unpersuasiveness of claimant's medical experts, as well as claimant's own discredited testimony, we are not persuaded that he has suffered permanent impairment as a result of his compensable neck injury. Consequently, we find that he is not entitled to an award of unscheduled permanent disability.

ORDER

The Referee's order dated March 30, 1987 is affirmed.

DELBERT G. DAVIS, Claimant
Malagon & Moore, Claimant's Attorneys
Cummins, et al., Defense Attorneys

WCB 86-09371
April 27, 1988
Second Order on Reconsideration

Claimant has requested reconsideration of the Board's Order on Reconsideration dated February 5, 1988, which affirmed its prior Order on Review that, inter alia, awarded claimant's attorney a $500 attorney fee for services on Board review. On March 4, 1988, the Board's order was abated and the self-insured employer was granted an opportunity to respond. Having received the employer's response, the Board has reconsidered the matter.

Specifically, claimant's attorney asserts that in a prior unrelated case he was awarded a $1000 attorney fee for services on Board review. He also asserts that he has gained considerable

expertise in representing injured workers with carpal tunnel syndrome. The employer's attorney responds that although the relative expertise of claimant's attorney is a relevant factor, his fee should be based on the time devoted to this particular case.

Pursuant to OAR 438-15-010(6), the amount of a reasonable attorney fee shall be determined by considering the following factors: (1) the time devoted to the case; (2) the complexity of the issue(s) involved; (3) the value of the interest involved; (4) the skill and standing of the attorneys; (5) the nature of the proceedings; (6) the result secured for the represented party; (7) the risk in a particular case that an attorney's efforts may go uncompensated; and (8) the assertion of frivolous issues or defenses. See also 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, claimant's attorney submitted a four and one-half page Respondent's Brief along with copies of three unrelated Opinion and Orders. The brief "accepted" the Referee's statement of facts. Claimant's attorney estimates that he spent six hours reviewing the hearing's transcript, reviewing the Appellant's Brief, and writing his Respondent's Brief. The employer's attorney suggests that should the Board decide to increase claimant's attorney's fee, the award should not exceed an hourly rate of $100 per hour. However, we agree that claimant's attorney has developed significant expertise in the carpal tunnel area and that an enhanced hourly fee is appropriate.

Following our review of the record and after consideration of the aforementioned factors as each pertains to this particular case, we modify our prior order and find that a reasonable attorney fee for services on Board review is $750.

Accordingly, as modified herein, we adhere to and republish our January 20, 1988 Order on Review, effective this date.

IT IS SO ORDERED.

MARVIN R. HEFFLEY, Claimant
Tennyson & Winemiller, Claimant's Attorneys
Carrol Smith (SAIF), Defense Attorney

WCB 87-04796
April 27, 1988
Order on Review

Reviewed by Board Members Ferris and Crider.

Claimant requests review of Referee Bennett's order that: (1) increased the award of scheduled permanent partial disability for his left leg from 35 percent (52.5 degrees) to 45 percent (67.5 degrees); and (2) increased the award of scheduled permanent partial disability for his right foot from 25 percent (33.75 degrees) to 35 percent (47.25 degrees).

ISSUE

What is the extent of claimant's scheduled permanent partial disability for his left leg and right foot?

FINDINGS OF FACT

Claimant sustained bilateral comminuted distal tibial

fractures and worsened a preexisting degenerative condition in his left knee on June 26, 1985 in the course of his employment as a truck driver when he jumped from the hood of a dump truck about eight feet to the ground to avoid being hit by a falling piece of metal. The ankle injuries were treated surgically by Dr. Baskin, an orthopedic surgeon. The claim was closed by Determination Order dated February 26, 1987 with scheduled awards of 35 percent (52.5 degress) for the left leg and 25 percent (33.75 degrees) for the right foot.

Claimant's limitations as a result of the industrial accident are as follows. Range of motion in both ankles is limited to 0 degrees of dorsiflexion, 20 degrees of plantar flexion and 5 degrees of inversion and eversion. Claimant is unable to stand or walk for more than an hour due to bilateral ankle pain. He cannot squat, crawl or climb. Claimant has full range of motion in his knee, but experiences pain and a feeling of instability with activity. He has never fallen as a result of the instability.

OPINION AND CONCLUSIONS

Extent of scheduled permanent partial disability is measured by the permanent loss of use or function of the injured member due to the industrial injury. ORS 656.214(2). In determining loss of use or function, we consider the medical and lay evidence in light of the rules set forth in OAR chapter 436, division 30. We apply these rules as guidelines, not as restrictive mechanical formulas. See SAIF v. Baer, 61 Or App 335, 337-38, rev den 294 Or 749 (1983); Isabel Aparicio, 38 Van Natta 421, 421-22 (1986). Loss of use or funtion does not necessarily correlate with mechanical impairment, although mechanical impairment is usually an important consideration. See Boyce v. Sambo's Restaurant, 44 Or App 305, 308 (1980).

Under OAR 436-30-300, mechanical impairment for each of claimant's ankles is as follows: loss of inversion, 4.5 percent; loss of eversion, 3 percent; loss of dorsiflexion, 7 percent; and loss of plantar flexion, 7 percent; for a total of 21.5 percent. Considering the disabling pain in claimant's ankles, which we rate as moderate, see OAR 436-30-340(2), and the limitations on squatting, crawling and climbing, we conclude that a proper award for each ankle (foot) is 35 percent. Claimant has no mechanical impairment of the left knee. Considering the pain and instability of claimant's knee, which we rate as mild, we conclude that a proper award for claimant's knee (leg) is 15 percent. See OAR 436-30-340(2) & (5). Converting claimant's left foot award to leg value, see OAR 436-30-320, and combining it with the award for the knee, see OAR 436-30-005(4); 436-30-350; 436-30-230(4), we conclude that a proper award for the left leg is 42 percent.

The Referee awarded claimant 35 percent for his right foot (ankle) and 45 percent for his left leg (ankle and knee). Based upon the foregoing analysis, we conclude that claimant has failed to prove entitlement to awards greater than those granted by the Referee.

ORDER

The Referee's order dated December 2, 1987 is affirmed.

MATTHEW W. JOHNSON, Claimant
Patrick Lavis, Claimant's Attorney
Nelson, et al., Defense Attorneys

WCB 87-14136
April 27, 1988
Amended Order of Dismissal

On March 31, 1988, in accordance with the insurer's withdrawal of its request for review, the Board issued its Order of Dismissal. Claimant has requested an insurer-paid attorney fee for prevailing against the insurer's appeal of the Referee's order.

The request for an insurer-paid attorney fee is denied. Where an insurer's or employer's request for Board review is dismissed prior to a decision on the merits, claimant is not entitled to an attorney fee. 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).

Accordingly, our March 31, 1988 order is withdrawn. As supplemented herein, we adhere to and republish our March 31, 1988 order, effective this date.

LANCE E. LEAVITT, Claimant
Flaxel, Todd, et al., Claimant's Attorneys
Dennis Ulsted (SAIF), Defense Attorney

WCB 87-18345
April 27, 1988
Order of Remand

Claimant requested Board review of Referee Quillinan's order that upheld the SAIF Corporation's denial of claimant's "new injury" claim for his current right elbow and arm condition. Prior to conducting our review, claimant asked that this matter be immediately remanded for the taking of additional evidence. The motion for remand is granted.

FINDINGS

The relevant facts are as follows. In August 1986, claimant sustained a compensable right elbow and arm injury while working for a prior employer, insured by SAIF. Shortly thereafter, he began working with the present employer, also insured by SAIF. On September 2, 1987, claimant filed a "new injury" claim, contending that he had injured his right arm in April 1987 while working for the present employer.

On September 8, 1987, claimant's attorney advised SAIF that he was representing claimant and was requesting all claim documents concerning the 1986 injury. In addition, claimant's attorney stated that a "new injury" claim regarding the 1987 incident had been filed. On October 9, 1987, claimant's attorney provided SAIF with a copy of his retainer agreement pertaining to claimant's 1987 injury claim.

On October 30, 1987, SAIF denied the "new injury" claim. On December 15, 1987, claimant requested a hearing concerning this denial. Claimant also requested SAIF to provide copies of all present and future medical documents and other information pertaining to the claim.

In November and December 1987 SAIF received several documents concerning claimant's right elbow and arm condition. Included in these documents were: (1) September 1987 through December 1987 chart notes from Dr. Bert, claimant's treating

orthopedist; (2) physical therapy notes from September 1987 through October 1987; and (3) a December 14, 1987 medical report from Dr. Whitney, a consulting orthopedist.

The aforementioned documents were not provided to claimant's attorney prior to the January 26, 1988 hearing. Unaware that these materials had been supplied to SAIF and not provided to him, claimant raised no objection to the closing of the hearing record.

On February 22, 1988, the Referee upheld SAIF's denial. Following claimant's request for Board review from the Referee's order, his counsel received a copy of the aforementioned documents. These materials were supplied in conjunction with claimant's 1986 injury claim with SAIF.

CONCLUSIONS

Should we determine that a case has been improperly, incompletely, or otherwise insufficiently developed, we may remand to the Referee for further evidence taking, correction, or other necessary action. ORS 656.295(5). To merit remand, it must be established that the evidence relevant to the issues raised in the remand 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).

Claimant contends that the omission of the aforementioned documents from the present record renders it incompletely developed. Moreover, he submits that the omission of these chart notes and medical report from the record was attributable to SAIF's failure to comply with discovery rules and provide him with a copy prior to the hearing. SAIF responds that the materials were contained in the 1986 injury claim file, rather than the 1987 injury claim file. Since no hearing request concerning the 1986 injury claim was pending, SAIF asserts that it was under no obligation to provide the documents. Furthermore, SAIF contends that the documents do not supply new or additional evidence. Consequently, SAIF argues that this matter should not be remanded.

After conducting our review of this matter, we find the omitted chart notes and medical report relevant to the question of whether claimant's injury claim is compensable. Therefore, we are persuaded that the present record, without the inclusion of the aforementioned documents, is insufficiently developed.

Furthermore, we find that this omission is directly related to SAIF's failure to timely respond to claimant's attorney's requests for information concerning claimant's right elbow and arm condition. We do not consider SAIF's actions to have been intentional. Yet, under these circumstances, we conclude that the report was unobtainable by claimant with due diligence prior to the hearing. To hold otherwise would shift the burden of obtaining an insurer-generated report to claimant's counsel when the report was not furnished to counsel even though a demand for the report was made in accordance with OAR 438-07-015(2).

Accordingly, the Referee's order is vacated. This case

is remanded to Referee Quillinan with instructions to reconsider this matter in light of this additional evidence.

ORDER

The Referee's February 22, 1988 order is vacated. This matter is remanded to Referee Quillinan for further action consistent with this order.

CLARENCE MISENHIMER, Claimant
Alice M. Bartelt, Defense Attorney
Scheminske & Lyons, Defense Attorneys

WCB 87-03439 & 86-09600
April 27, 1988
Amended Order of Dismissal

Counsel for Argonaut Insurance seeks Board authorization of a client-paid fee for services rendered which culminated in our April 8, 1988 Order of Dismissal.

After review of the statement of services and the attorney retainer agreement, and considering the factors set forth in OAR 438-15-010(6), we approve a fee to be paid by Argonaut Insurance to its attorney, not to exceed $440.

Accordingly, our April 8, 1988 order is abated and withdrawn. As amended herein, we adhere to and republish our April 8, 1988 order in its entirety. The parties' rights of appeal shall run from the date of this order.

IT IS SO ORDERED.

ROBERT A. PERINI, Claimant
Bischoff & Strooband, Claimant's Attorneys
Brian L. Pocock, Defense Attorney

WCB 86-05896 & 86-16035
April 27, 1988
Order on Review

Reviewed by Board Members Crider and Johnson.

The self-insured employer requests review of Referee Howell's order that granted claimant an award of permanent total disability in lieu of an award by Determination Order of 30 percent (96 degrees) unscheduled permanent partial disability for his neck and shoulders. The issue is extent of disability.

The Board affirms and adopts the order of the Referee. An assessed fee would be appropriate under ORS 656.382(2) and OAR 438-15-070. No statement of services, however, has been received from claimant's attorney as required by OAR 438-15-010(5) and 438-15-027. We thus cannot authorize an assessed fee at this time.

ORDER

The Referee's order dated May 8, 1987 is affirmed. Counsel for the self-insured employer is authorized to bill a client-paid fee of up to $400 for services on Board review.

VONE M. POWERS, Claimant
Vick & Gutzler, Claimant's Attorneys
John Motley (SAIF), Defense Attorney

WCB 87-06413
April 27, 1988
Order on Review

Reviewed by Board Members Ferris and Crider.

Claimant requests review of Referee Zucker's order that dismissed his request for hearing.

ISSUE

Whether the Referee erred in dismissing claimant's request for hearing.

FINDINGS OF FACT

In April 1987, claimant timely filed a Request for Hearing. In his request, claimant checked the box labeled "Inactive Status." The Hearings Division acknowledged claimant's request and indicated that the case was being placed in inactive status until January 22, 1988.

After the SAIF Corporation filed its response, claimant filed a second request for hearing in August 1987, which again checked the box labeled "Inactive Status." The following month, claimant's attorney wrote the Hearings Division and informed it of several dates that he would not be available for hearing.

On October 22, 1987, the Hearings Division issued a Notice of Hearing, which set a hearing for December 14, 1987. On December 17, 1987, the Referee entered an Order of Dismissal.

CONCLUSIONS OF LAW

We may remand to the Referee should we find that the record has been "improperly, incompletely or otherwise insufficiently developed. ORS 656.295(5). Here, the record is devoid of any motions, correspondence, or exhibits concerning the dismissal of claimant's requests for hearing. There is no transcript of a hearing. The Referee's order contains no explanation of her decision to dismiss claimant's requests for hearing. Under such circumstances, we find that the record before us has been improperly, incompletely, and insufficiently developed.

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

ORDER

The Referee's order dated December 17, 1987 is vacated and this matter is remanded to the Presiding Referee for further proceedings consistent with this order.

EDWIN R. STOKLEY, Claimant
Welch, Bruun & Green, Claimant's Attorneys
Nelson, et al., Defense Attorneys

WCB 87-08421
April 27, 1988
Order of Dismissal (Remanding)

The insurer has requested Board review of Referee Zucker's March 14, 1988 and March 16, 1988 orders. We have reviewed the requests to determine whether we have jurisdiction to consider them. We conclude that the requests for review are premature.

FINDINGS

On March 14, 1988, the Referee issued an Opinion and Order. On March 16, 1988, the Referee issued an Order of Abatement, withdrawing the previous order for reconsideration. The insurer requested Board review of both orders. The requests for review were filed on April 12, 1988.

CONCLUSIONS

Since the Referee's March 14, 1988 order had been abated prior to the filing of the insurer's request for Board review, we lack jurisdiction to consider the issues raised by the request for review of that order. Furthermore, because the March 16, 1988 abatement order neither finally disposed of, nor allowed or fixed the amount of claimant's compensation, it is not a final appealable order. See Price v. SAIF, 295 Or 311, 315 (1984); Lindamood v. SAIF, 78 Or App 15, 18 (1986). Therefore, we lack jurisdiction to consider that order as well.

Accordingly, the requests for Board review are dismissed as premature. This matter is remanded to Referee Zucker for further action.

IT IS SO ORDERED.

ROBERT D. BURNS, Claimant
Cowling & Heysell, Claimant's Attorneys
Luvaas, Cobb, et al., Defense Attorneys

WCB 86-12488
April 29, 1988
Order on Review

Reviewed by Board Members Ferris and Crider.

The insurer requests review of Referee Mongrain's order that set aside its partial denial of claimant's current low back condition. In its brief, the insurer has discussed information from a treatise on orthopedics, and included a photocopy of a lateral view of the spine. These materials are not otherwise in the hearing record, and cannot be considered on Board review. Groshong v. Montgomery Ward Co., 73 Or App 403 (1985). As a result, 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 compensability.

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 find that the record has not been improperly, incompletely or otherwise insufficiently developed. Furthermore, we are persuaded that the additional evidence presented in the insurer's brief was obtainable with due diligence. Accordingly, remand is not warranted.

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

Claimant failed to timely file his brief on review. 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 27, 1987 is affirmed. Claimant's attorney is awarded $200 for services on Board review, to be paid by the insurer.

ANITA L. KEUSCHER, Claimant
Michael Dye, Claimant's Attorney
Gary Wallmark (SAIF), Defense Attorney

WCB 86-06175
April 29, 1988
Order on Review

Reviewed by Board Members Ferris and Crider.

Claimant requests review of Referee Foster's order that found that claimant was not entitled to additional temporary disability benefits. On review, claimant contends that the SAIF Corporation was not entitled to consider her unemployment benefits as "wage earnings" for purposes of calculating her temporary disability benefits.

ISSUE

On review, the issue is computation of temporary disability compensation.

FINDINGS

The Board adopts the findings of fact contained in the "Findings" section of the Referee's order.

CONCLUSIONS AND OPINION

The Board affirms the order of the Referee, as supplemented by the following discussion of applicable legal principles.

In calculating temporary partial disability compensation, post-injury wage earnings available from any kind of work are offset against wages at the time of the injury. ORS 656.212; OAR 436-60-030. When a worker is receiving unemployment benefits by representing an ability to work, those benefits may be treated as post-injury wages. Wells v. Pete Walker's Auto Body, 86 Or App 739 (1987); Daniel J. Cannon, 35 Van Natta 1181 (1983).

ORDER

The Referee's order dated July 23, 1987 is affirmed.

THOMAS H. WHITTLINGER, Claimant
Olson Law Firm, Claimant's Attorney
John B. Motley (SAIF), Defense Attorney

WCB 86-09059
April 29, 1988
Order on Review

Reviewed by Board Members Ferris and Crider.

Claimant requests review of Referee Garaventa's order that upheld the SAIF Corporation's denial of current chiropractic treatments as being unrelated to his compensable left arm and back injury. On review, the issue is compensability of current medical services. We affirm.

FINDINGS OF FACT

In July 1983, claimant sustained a compensable injury when a stack of steel centers slipped and pinned his chest against a steel frame. Dr. Saunders, M.D., noted symptoms in the left chest, lacerations, contusions, abrasions in the left hand, upper left and lower forearm. A laceration was sutured and claimant was instructed to return in 10 days.

Upon claimant's return, he complained of pain in the left elbow. Hot soaks were prescribed and he was to return in one to three weeks if the symptoms persisted. Claimant did not return to Dr. Saunders or seek treatment elsewhere. On August 1, 1983, the claim was accepted as nondisabling.

In February 1986, claimant began treating with Dr. Kelley, chiropractor, for headaches, pain, and stiffness in the neck. Dr. Kelley diagnosed costo-vertebral facet syndrome in the rib area and upper thoracic sprain.

The history provided by claimant to Dr. Kelley was not complete. Although claimant informed Dr. Kelley of his compensable injury, he did not report that he had received treatment for it or that he was working regular hours.

The treatment claimant has been receiving from Dr. Kelley is not related to his July 7, 1983 injury, but rather to his strenuous activities and work since the compensable injury.

CONCLUSIONS OF LAW AND OPINION

Claimant contends the treatment he has been receiving from Dr. Kelley since February 3, 1986, is related to the compensable July 7, 1983 injury. Claimant relies on Dr. Kelly's opinion that the treatment is related to the injury.

The Referee reasoned that, because Dr. Kelley did not see claimant until two and one-half years after the injury and based his medical opinion on inaccurate information concerning treatment and work subsequent to the injury but prior to his examination, his opinion is not persuasive. We agree.

On February 3, 1986, Dr. Kelley examined claimant. He diagnosed costo-vertebral facet syndrome with positive rib sign,

upper thoracic sprain/strain injury with muscle spasm, and bilateral shoulder crepitus. Claimant was treated with chiropractic manipulation and physiotherapy. The doctor felt that the symptoms were consistent with the history of the injury as presented by claimant.

Dr. Kelley did not have an accurate medical history. He thought claimant suffered back symptoms immediately after the compensable injury and had not received treatment for them. Furthermore, claimant told Dr. Kelley that he had not been doing heavy lifting, stretching, straining and twisting since the injury. The evidence and testimony is to the contrary.

Dr. Saunders, the treating physician at the time of the 1983 accident, testified that the type of injury described by claimant is not the kind expected to cause neck or back strain. He opined that it was not medically reasonable to relate claimant's current condition to the compensable injury.

Dr. Saunders had an accurate history. He opined that if claimant's back strain had been caused by his compensable injury the symptoms would have appeared earlier. He went on to explain that the more probable cause of claimant's present condition was his work which requires substantial physical movement and exertion. His opinion is the more persuasive.

Claimant has failed to establish that the treatment he sought from Dr. Kelley for his condition is related to the compensable July 7, 1983 injury.

ORDER

The Referee's order dated April 16, 1987 is affirmed.

JESSICA G. BANNESTER, Applicant
Ann Kelley, Assistant Attorney General

WCB CV-88003
May 3, 1988
Crime Victim Order of Remand

This matter is before the Board pursuant to applicant's request for review concerning the Department of Justice's Findings of Fact, Conclusions and Order on Reconsideration dated December 28, 1987. By its order, the Department denied compensation to applicant under the Compensation of Crime Victims Act. (ORS Chapter 147).

The record provided to the Board by the Department contains a "Special Report" from the investigating officer. This report was prompted by applicant's concerns that the officer's original report inaccurately reflected events concerning the incident in question. Because of these concerns, the officer allowed applicant to provide a supplemental report, which was attached to the "Special Report" and submitted to the Department.

The record also contains a medical report from applicant's current treating physician. Although several reports and medical bills are in the record, this report is the only one from her treating physician. Furthermore, the report discusses applicant's present condition and its relationship to the incident.

Both of the aforementioned reports were received by the Department after the issuance of its Order on Reconsideration. Although these reports were not considered by the Department, they have been forwarded to the Board as part of "the entire Department record." See OAR 438-82-025.

We are not authorized to consider evidence that has not been previously considered by the Department. ORS 147.155(5). Consequently, we are presently unable to review these reports. Yet, we are also empowered to conduct proceedings in any manner that will achieve substantial justice. Considering the aforementioned reports' relevancy to the issues currently on appeal, we conclude that substantial justice would be served by the Department's consideration of these reports.

Accordingly, this matter is remanded to the Department of Justice Crime Victims' Compensation Program for further consideration of this record. The Department is directed to reconsider this record, including the aforementioned reports. Should applicant continue to disagree with the Department's decision following its reconsideration, he may petition the Board for review of the Department's order.

IT IS SO ORDERED.

CHARLES V. BARNETT, Claimant
Flaxel, Todd, et al., Claimant's Attorneys
Davis & Bostwick, Defense Attorneys

WCB 87-14849
May 3, 1988
Order on Review

Reviewed by Board Members Johnson and Ferris.

Claimant requests review of those portions of Referee Quillinan's order that: (1) declined to assess a penalty and attorney fee for an alleged unreasonable failure to timely accept or deny his claim for a low back injury; and (2) declined to assess a penalty and attorney fee for an alleged failure to timely process a medical bill. The issues are penalties and attorney fees.

FINDINGS OF FACT

Claimant is a 40-year-old laborer who had several prior back injuries. Claimant obtained employment at Precision Wood Concepts (Precision) through Express Temporary Services (Express). Claimant was interviewed and hired by Precision's supervisor, Rob Robinson, and believed that his employer was Precision. Claimant's checks for his wages came through the Express office located in Redding, California.

On or about December 6, 1986, claimant had another incident of low back pain. He orally reported it to his supervisor -- Robinson -- at Precision on or about December 8, 1986. He sought medical treatment on December 9, 1986 from Dr. Kadas. He was taken off work and underwent a CT scan on December 19, 1986. On January 9, 1987, Dr. Serbu, neurologist, released claimant to return to work.

When claimant failed to receive any temporary disability benefits, he made further inquiry of Robinson, who then asked him to complete and sign a Form 801. Claimant filed the claim form on January 12, 1987. Someone other than claimant typed in the name

of the employer shown on that form as "Express Temporary Services/Precision Wood". The claim form was imprinted with the name of the SAIF Corporation at the top. The claim was mailed to SAIF, who subsequently denied the claim on January 29, 1987, on the basis that claimant was not in the employ of its insured -- the Portland branch of Express.

The Redding, California branch of Express acknowledged in writing that it had notice of the claim on February 20, 1987. On April 22, 1987, Underwriters Adjusting Company, representing the insurer for the Redding, California branch of Express, accepted the claim. Claimant received a check drawn April 29, 1987, paying claimant temporary disability benefits for the period December 6, 1986, through January 14, 1987.

A Determination Order issued August 3, 1987, awarding temporary benefits from December 6, 1986 to January 9, 1987, resulting in a five day overpayment.

As of November 27, 1987, the bill for the CT scan had not yet been paid. There is no indication in the record as to when or if Underwriters has ever received this bill.

CONCLUSIONS OF LAW AND OPINION

It is axiomatic that an insurer has no obligation to pay a medical bill of which it has no knowledge. The evidence here is that Underwriters had no knowledge of the unpaid bill for the CT scan. Furthermore, Underwriters has paid all other medical bills. We conclude that no basis exists for the imposition of a penalty or attorney fee on this issue.

The other issue before us involves the timeliness of Underwriters acceptance of the claim. An insurer is required to furnish claimant with written notice of acceptance or denial of a claim within 60 days after the employer has notice or knowledge of the claim. ORS 656.262(6). Claimant argues that Robinson, his supervisor at Precision, was the agent of Express for purposes of notice of his claim. Claimant notes that Robinson had notice of the claim not later than January 12, 1987, and that this notice should be imputed to Express. If we were to accept this argument, then the Underwriters/Express denial dated April 22, 1987 would be untimely. We conclude, however, that we need not address this question. Even in the absence of application of an agency theory, Express had notice of the claim more than 60 days before issuing its acceptance.

Express had notice of the claim on February 20, 1987, at which time a State of California report-of-injury form was completed and signed by an Express employee. Underwriters issued its acceptance on April 22, 1987, sixty-one days following notice of the claim. Underwriters offered no explanation for the untimely acceptance. We conclude that a penalty and attorney fee would generally be appropriate under these circumstances.

However, the Referee previously awarded a 25 percent penalty for untimely payment of temporary benefits. We have previously noted that combined penalties cannot exceed 25 percent of the compensation "then due." ORS 656.262(10); Marlene W. Ritchie, 37 Van Natta 1088, 1097 (1985). We are statutorily constrained from awarding an additional penalty beyond that awarded by the Referee.

There is authority, however, for an attorney fee for each unreasonable claims processing violation regardless of whether any penalty may be assessed. See ORS 656.382(1); Mischel v. Portland General Electric Company, 89 Or App 140 (1987); Rob Cohen, 39 Van Natta 649, 652 (1987). We, therefore, assess an attorney fee to be paid by Underwriters for its untimely acceptance of claimant's claim.

ORDER

The Referee's order dated December 31, 1987 is affirmed in part and reversed in part. That portion of the Referee's order that declined to assess an attorney fee for the Underwriters' untimely acceptance of the claim is reversed. Claimant's attorney is awarded $250, to be paid by Underwriters. The remainder of the Referee's order is affirmed.

TERRY L. BILLUPS, Claimant
Peter O. Hansen, Claimant's Attorney
Rankin, VavRosky, et al., Defense Attorneys
Ray Smitke (SAIF), Defense Attorney

WCB 86-13726
May 3, 1988
Order on Review (Remanding)

Reviewed by Board Members Johnson and Crider.

Claimant requests review of Referee Fink's order that dismissed his request for hearing. The issue is whether dismissal was appropriate and, if not, whether remand is warranted.

FINDINGS OF FACT

Claimant compensably injured his left ankle/foot in March 1979, while working as a psychiatric aide for the SAIF Corporation's insured. As a result of the injury, a preexisting bunion on his left foot became irritated, necessitating surgical repair in July 1979. Following the surgery, he began working as an apartment manager.

A Determination Order issued in September 1979, awarding claimant 5 percent scheduled permanent disability. That award was increased to 10 percent by a stipulation.

In March 1980, claimant underwent a removal of bone spurs in the left foot. A few months later, he began working for the instant self-insured employer as a fabrication maintenance assistant. In 1981, Dr. Tongue, orthopedist, performed a bunionectomy on claimant's right foot. Claimant was off work for approximately four months and then returned to work for the employer. Thereafter, he went without medical treatment until reexamination by Dr. Tongue on January 25, 1985. Claimant, at that, time complained of chronic left ankle and leg pain.

In April 1985, claimant began to treat with Dr. Schader, surgeon. The following month, Schader performed an arthrotomy and removal of an osseous loose body in claimant's left ankle.

Thereafter, claimant apparently requested the Board to exercise its Own Motion authority and reopen his March 1979 left foot claim. In June 1985, the Board reopened the claim and ordered SAIF to begin paying temporary disability benefits from

January 25, 1985 until proper closure. Subsequently, the Board closed the claim with temporary disability benefits payable through January 20, 1986, but no award of permanent disability.

In September 1986, claimant filed an occupational disease claim against the instant employer. On the claim form, claimant reported the date of injury as "gradual onset" and stated:

> "Work activity and conditions at [the employer] worsened my foot condition, and caused back pain and stiffness do [sic] to change in the way I carry my weight."

Later that month, the employer denied the claim on the basis of timeliness and compensability. Claimant requested a hearing.

In December 1986, the Board issued an Own Motion Determination On Reconsideration awarding claimant 20 percent scheduled permanent disability, in lieu of all previous awards.

The next month, Dr. Hoff, orthopedist, reviewed certain medical records and opined that claimant's work activities at the employer were the major contributing cause of a temporary worsening of his foot and ankle condition.

In February 1986, the employer moved for dismissal of claimant's Request for Hearing. According to the employer, the doctrine of res judicata barred claimant from litigating his occupational disease claim. One day prior to the scheduled hearing, the Referee heard oral argument concerning the employer's dismissal motion. Two days later, the Referee dismissed claimant's Request for Hearing, stating, inter alia:

> "Claimant submitted to surgery in May, 1985 by Dr. Schader. In November, 1985 he first consulted Dr. Hoff. * * * Hoff records in part that claimant's work activities at [the employer] is what 'aggravated a significant portion of his symptoms.'
>
> "Based on all of the medical documentation, together with argument by [the employer's attorney] in her Motion to Dismiss, I conclude the motion ought to be granted."

CONCLUSIONS OF LAW AND OPINION

The Referee should not have dismissed claimant's Request for Hearing.

The doctrine of res judicata "bars claims which were or could have been litigated in the prior proceeding." Consolidated Freightways v. Poelwijk, 81 Or App 311, 315 (1986); see also Million v. SAIF, 45 Or App 1097, 1102 (1980).

Here, no workers' compensation proceeding has occurred since the employer denied claimant's occupational disease claim. Even the claim against SAIF, which had been reopened under the Board's own motion authority in June 1985, had been closed as of February 10, 1986--seven months before the occupational disease claim was denied by the employer. Claimant did request that the

Board reconsider its order closing the own motion case. That request resulted in the Board's December 1986 order, granting an additional award of permanent partial disability. However, no new issues could have been raised in the request for reconsideration. Thus, after the time the compensability issue was joined by issuance of the employer's denial of claimant's occupational disease claim, no Board proceeding occurred in which any additional issues could have been raised.

The employer nevertheless contends that, even though the occupational disease issue had not been framed by the filing of a claim and issuance of a denial, when claimant sought an own motion reopening of his 1979 injury claim, claimant is barred by res judicata principles from litigating the denial now. We understand the employer to argue that the occupational disease claim and the own motion reopening each seek to assign responsibility for a single condition to a different employer/insurer and, therefore, that they must be litigated in a single proceeding. Although it has been the Board's practice to consolidate pending cases for hearing where consolidation is necessary in the interests of economy, neither the statute nor the rules require a claimant to expedite filing of a claim against one insurer simply because a related claim is pending before the Hearings Division. Thus, because there was no dispute cognizable in any proceeding before the Board at the time of any prior proceeding, claimant is not barred from raising this occupational disease issue.

Moreover, even if the employer's denial had issued before the own motion proceeding was completed by closure of the 1979 claim, claimant could not have litigated the disease claim against the insurer in the own motion proceeding. The Board's own motion jurisdiction only extends to "former findings, orders or awards" and to situations in which claimant's aggravation rights under ORS 656.273 on the former injury have expired. Here, claimant's occupational disease claim was a new claim. It had never been accepted. No order had issued with respect to it. Having never been closed, aggravation rights under this claim had not begun to run. Inasmuch as there have been no "findings, orders or awards" concerning the 1986 occupational disease claim, no issue pertaining to that claim was either raised or raisable in the own motion proceeding. Accordingly, res judicata does not apply to the instant case and does not bar claimant's request for hearing.

Further, in dismissing claimant's request for hearing, the Referee relied, in part, upon the medical record. Specifically, the order refers to Dr. Hoff's November 1985 notation that claimant's work activities "aggravated a significant portion of his symptoms." We understand this reference to suggest that--because Dr. Hoff made the quoted comments more than 180 days before the occupational disease claim was filed--the claim was not filed within the time period prescribed by former ORS 656.807(1). If so, the Referee erred in deciding the timeliness issue without hearing.

We may remand to the Referee if we find that the record has been "improperly, incompletely or otherwise insufficiently developed." ORS 656.295(5). Here, we find that inasmuch as the Referee improperly dismissed claimant's request for hearing, remand is appropriate.

ORDER

The Referee's dismissal order dated February 11, 1987, is reversed and this matter is remanded to the Hearings Division for further proceedings consistent with this order.

CARL R. BRADLEY, Claimant
Francesconi & Associates, Claimant's Attorneys
Schwabe, et al., Defense Attorneys
Roberts, et al., Defense Attorneys

WCB 86-17149 & 86-14461
May 3, 1988
Order on Review

Reviewed by Board Members Crider and Ferris.

Claimant requests review and Maryland Casualty Company cross-requests review of Referee Thye's order that: (1) set aside Maryland Casualty's denial of claimant's aggravation claim for a low back condition; (2) upheld CIGNA Insurance Companies' denial of claimant's "new injury" claim for the same condition; and (3) declined to award claimant's attorney a fee for services at hearing. No briefs were submitted on Board review. We affirm.

ISSUES

1. Responsibility for claimant's low back condition.

2. Attorney fees in a responsibility case.

FINDINGS OF FACT

Claimant is a 32-year old warehouse supervisor who injured his low back lowering a box on August 7, 1985 while working for Transpacific Enterprises, Maryland Casualty's insured. An internist diagnosed lumbosacral strain and facet syndrome with sciatic notch tenderness. The day following the accident, claimant sought treatment from Dr. Kennedy, a chiropractor, who found claimant to be in "severe" pain and diagnosed a moderate to severe lumbosacral disc protrusion. Although not yet found medically stationary, claimant was released to return to regular work on September 12, 1985. He was found medically stationary January 14, 1986 although he still continued to have "periodic twinges" not affecting his work.

Closing examination on February 28, 1986 found claimant feeling 85 to 90 percent improved although he continued to experience tightness in the mornings with mild left leg pain, for which continued palliative care was recommended.

Claimant continued working until April 30, 1986, when he suffered an aggravation and was treated intensively by Dr. Kennedy through May 7, 1986.

Claimant had arranged to start working for Collins Food Service, Cigna's insured, in mid-May 1986 and took a vacation after May 7, 1986.

The August 7, 1985 injury claim was closed by Determination Order of May 15, 1986, awarding temporary disability but no permanent disability.

Claimant changed jobs to Collins Food Service because of higher pay, even though his job there as a loader was heavier than his

job with Transpacific Enterprises. When claimant began his job with Collins Food Service, he experienced primarily morning stiffness. On June 19, 1986, he felt a dull ache after he had been lifting heavy boxes approximately six hours, but he worked out his shift. The ache was on the left side of his low back in the same area that he had the sharp and immediately disabling pain on August 7, 1985. The pain following work on June 19, 1986 did not become severe until the next morning, when he had difficulty arising. He has not worked since June 19, 1986.

Examination of claimant by Dr. Intile, Jr., an internist, on June 30, 1986 found left lumbar paraspinal muscle spasm as a result of work related traumatic lumbar myositis. Medication was prescribed and claimant was released to regular work on July 7, 1986. Dr. Kennedy released claimant to work with a 35-pound lifting restriction on July 8, 1986. On August 20, 1986, CIGNA issued a denial, as did Maryland Casualty on November 17, 1986. An Order Designating a Paying Agent was issued December 5, 1986 ordering Maryland Casualty to process the claim.

On January 6, 1987, Dr. Kennedy wrote that the symptoms and findings on June 19, 1986 were similar but not as severe as those on August 7, 1985. Claimant was found medically stationary. However, a permanent lifting restriction of 35 pounds was recommended, as well as continued palliative care. Dr. Kennedy opined that the June 19, 1986 injury did cause a material worsening of claimant's preexisting condition and that it resulted in further permanent partial disability.

A March 12, 1987 Determination Order closed the claim with an award of five percent unscheduled permanent partial disability.

Dr. Intile subsequently opined that there was no evidence that claimant experienced any worsening of his pre-existing low back condition as a result of the June 19, 1986 incident.

Upon our de novo review of the record, we find that claimant's work activities while employed by CIGNA's insured did not independently contribute to a worsening of his low back condition.

CONCLUSIONS OF LAW AND OPINION

The Board adopts the Referee's well-reasoned opinion.

ORDER

The Referee's order dated December 9, 1987, as supplemented herein, is affirmed. A client-paid fee not to exceed $510, payable to counsel for CIGNA Insurance Companies, is approved. A client-paid fee not to exceed $610, payable to counsel for Maryland Casualty, is approved.

LUANN M. BREEDEN, Claimant
Charles D. Maier, Claimant's Attorney
Schwabe, et al., Defense Attorneys

WCB 87-09362
May 3, 1988
Order on Review

Reviewed by Board Members Crider and Johnson.

The self-insured employer requests review of that portion of Referee Seymour's order that set aside its denial with respect to claimant's low back condition. On review, the issue is whether claimant sustained a compensable low back injury.

The Board affirms and adopts the order of the Referee.

Claimant's counsel is statutorily entitled to a reasonable attorney fee for services on review. ORS 656.382(2). Such a fee is defined as an "assessed fee." OAR 438-15-005(2). However, we cannot authorize an assessed fee unless claimant's counsel files a statement of services. OAR 438-15-010(5). Because no statement of services has been received to date, an assessed fee shall not be authorized.

The employer's counsel must seek Board approval of a reasonable attorney fee for services rendered on Board review. ORS 656.388(1). Such a fee is defined as a "client paid fee." OAR 438-15-005(5). However, we cannot authorize a client paid fee unless the employer's counsel files a statement of services. OAR 438-15-010(5). Because no statement of services has been received to date, a client paid fee shall not be authorized.

ORDER

The Referee's order dated November 30, 1987 is affirmed.

MARIA CAMPOS, Claimant
Ginsburg, et al., Claimant's Attorneys
Scheminske & Lyons, Defense Attorneys

WCB 87-08331
May 3, 1988
Order Denying Motion to Dismiss

Claimant has requested review of Referee Menashe's January 4, 1988 Order of Dismissal. The insurer has moved for an order dismissing the request on the ground that it was untimely filed. The motion is denied.

FINDINGS

Claimant's request, dated February 3, 1988, was received by the Board on February 4, 1988. The request was neither mailed by registered nor certified mail. Included with the request was a certificate of personal service by mail upon the employer and its insurer.

On February 11, 1988, claimant submitted an affidavit from an employee of her attorney's law firm. The employee certified that she mailed claimant's request for review to the Board on February 3, 1988.

Based on the affidavit of claimant's attorney's employee and the record as a whole, we find that the request for Board review was mailed on February 3, 1988.

CONCLUSIONS

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

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

Here, the thirtieth day after the Referee's January 4, 1988 order was February 3, 1988. Since claimant's request was neither mailed by registered nor certified mail and was actually received by the Board on February 4, 1988, after the date for filing, it is presumed to be untimely until claimant establishes that the mailing was timely. See OAR 438-05-046(1)(b).

As previously indicated, the aforementioned affidavit and the record as a whole establishes that the request for Board review was timely mailed. Consequently, the presumption of untimeliness has been overcome. See OAR 438-05-046(1)(b).

Accordingly, the motion to dismiss is denied. Claimant's reply to the insurer's respondent's brief shall be due seven days from the date of this order. Thereafter, this case will be docketed for Board review.

IT IS SO ORDERED.

DENNIS L. CHEMNITZER, Claimant
Callahan, et al., Claimant's Attorneys
Meyers & Terrall, Defense Attorneys

WCB 86-13136
May 3, 1988
Order on Review

Reviewed by Board Members Johnson and Ferris.

The self-insured employer requests review of Referee Foster's order that set aside its denial of claimant's request for authorization to participate in a hospital's back rehabilitation program. The issue on review is medical services.

FINDINGS OF FACT

Claimant, a 39-year-old truck driver, injured his back in late 1983. He has been treated conservatively, primarily by Dr. Gallagher, orthopedic surgeon. He received an award of 64 degrees for 20 percent unscheduled permanent disability by Determination Order issued November 20, 1986.

Claimant attempted to return to truck driving, but he was unable to do so. He subsequently obtained a clerical position with the employer, which he left in February 1987. At the time of the hearing, he was a full time student.

Dr. Gallagher states, in a November 1986 chart note, that he told claimant he would ask the "insurance company" [sic] to send him to the Back Evaluation Clinic at Salem General Hospital. He opined that this would be best because claimant could have a physical evaluation as well as work and psychological evaluations. Two days later, Dr. Gallagher sent a letter to the employer indicating that evaluation of all three areas would be most helpful to the employer, to the claimant, and to Dr. Gallagher himself.

Approximately two months later, the employer sent a letter to Dr. Gallagher inquiring, among other things, whether the Healthy Back Program at the YMCA would be beneficial to claimant. In his response, Dr. Gallagher stated that he would recommend the program at the hospital or at the YMCA. He further noted that if claimant was referred to the hospital program, a work restriction sheet could be filled out during a period of trial work.

The insurer notified claimant by letter dated April 3, 1987 that it was denying authorization for the hospital program, but that it was authorizing claimant's attendance at the YMCA program.

Dr. Gallagher stated a preference for the hospital program over the YMCA program. The Referee made no credibility finding. Based upon the content of claimant's testimony, we find him to be a credible and reliable witness.

CONCLUSIONS OF LAW AND OPINION

On review, the employer argues that claimant has not offered any evidence indicating that the hospital program is preferable to the YMCA program. The employer interprets Dr. Gallagher's statements as a recommendation of either program. The employer also disputes a statement by the Referee that "most" of claimant's treating physicians recommended the hospital program over the YMCA program.

The only physician to address this question was Dr. Gallagher. We, therefore, agree with the employer that the Referee's reference to "most" of claimant's treating physicians is not supported by the record. We disagree, however, with the employer's contention that Dr. Gallagher equated the two programs without recommending one program over the other. We interpret Dr. Gallagher's November 1986 chart note and letter as exhibiting a clear preference for the hospital program on the basis of its more extensive evaluation services. This preference was reiterated in Dr. Gallagher's February 1987 letter to the employer. We find further support for our conclusion in claimant's credible testimony.

The employer argues in the alternative that the proper interpretation of Dr. Gallagher's opinion is irrelevant because claimant testified that his school schedule would not allow him time to attend the three-week hospital program. Claimant also testified, however, that his school term ended three-to-four weeks following the hearing and that he would be available to attend the program at that time. We do not consider claimant's immediate unavailability to attend the hospital program dispositive.

We conclude that claimant has met his burden of proving that the hospital program is reasonable and necessary treatment for his compensable low back condition. We, therefore, affirm the order of the Referee.

ORDER

The Referee's order dated June 9, 1987 is affirmed. For services on Board review, claimant's attorney is awarded a reasonable attorney's fee of $500, to be paid by the self-insured employer. We approve a client-paid fee, not to exceed $230.

TIMOTHY H. CRUCHELOW, Claimant
Paul S. Bovarnick, Claimant's Attorney
Schwabe, et al., Defense Attorneys

WCB 86-06981 & 86-06982
May 3, 1988
Order on Review

Reviewed by Board Members Johnson and Crider.

Claimant requests review of Referee Shebley's order which upheld the insurer's denial of his occupational disease claim for a bilateral foot condition. On review, claimant contends that he sustained his burden of proving the compensability of his condition. We agree and reverse.

FINDINGS OF FACT

Claimant, 37 at the time of hearing, had worked 18 years as a sheet metal fabricator. For nearly all of those years, his job required that he stand on a concrete floor for over seven hours each day. In 1985 he began to experience severe foot pain, reduced foot motion and a sensation that his feet were going to give out. These symptoms diminished when he worked less.

Claimant has degenerative arthritis in both feet, which preexisted his employment. He has had a history of foot pain since his high school years when activities required prolonged standing. He was diagnosed then as having arthritis. In 1975 he developed more frequent foot pain which diminished during weekends or vacations when he was not standing or walking on concrete. He was diagnosed then as having a spur on the top of his left foot. His symptoms in 1975 were less severe and less persistent than those currently experienced.

Since he began working for the employer, claimant's degenerative arthritis condition has worsened. The worsening has been greater than that associated with the natural progression of degenerative arthritis. The greater worsening was caused by prolonged standing at work.

Dr. Robertson, claimant's treating podiatrist, first saw claimant in October 1985. At that time, Robertson found "very limited range of motion, particularly of inversion, eversion of both feet and more specifically of the left foot." X-rays revealed some degenerative joint changes and talar beaking. Diagnosing degenerative joint changes and possible tarsal coalition, Dr. Robertson described the tarsal coalition as a mechanical defect caused by the inability of the calcaneus to rotate due to a bony bridge across the joints.

Thereafter, Dr. Robertson saw claimant on four more occasions in 1985 and once in 1987. During these visits, Robertson prescribed orthotic devices and medication. During the January 1987 examination, he noted a little less range of foot motion and swelling on the left ankle.

Dr. Noall, an orthopedist, examined claimant once in April 1986. He diagnosed diffuse degenerative arthritis involving both feet. He observed no tarsal coalition in the right foot but noted that long-standing coalition was a "remote possibility" in the left foot.

Claimant was laid off work in December 1985. On February 26, 1986, he filed his occupational disease claim for "arthritis, tendonitis, bone spurs" in both feet and ankles. The insurer denied the claim on April 30, 1986.

CONCLUSIONS AND OPINION

The Referee upheld the denial. In so doing, the Referee was not persuaded by Dr. Robertson's opinion that prolonged standing for many years was the major contributing cause of the worsening of claimant's degenerative arthritis condition. The Referee discounted the persuasiveness of Robertson's opinion because the doctor failed to mention a work connection in his initial chart notes in 1985. We disagree with the Referee's decision and, instead, find claimant's occupational disease claim compensable.

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

This case presents a complex medical question. Hence, although claimant's testimony is probative, resolution of this case largely turns on the medical evidence. Uris v. Compensation Department, 247 Or 420, 426 (1967); Kassahn v. Publishers Paper Co., 76 Or App 105, 109 (1985).

Here, the medical evidence is undisputed that claimant has degenerative arthritis in his feet, which preexisted employment. Beyond that, however, the medical evidence is split.

Dr. Robertson, the treating podiatrist, opined that the cause of claimant's foot problems was "biomechanically from the design of his foot and from degenerative joint changes." Robertson explained that claimant's condition was caused by the abnormal position of the midtarsal and subtalar joints in his feet, which are subject to abnormal stress during prolonged standing. He added that the abnormal position and stress caused hypertrophy of the bone which, in turn, exacerbated the whole degenerative process. Robertson rated the probability as "high" that the increase in claimant's foot pain evidenced a change in the condition or structure of his feet. He concluded that prolonged standing for many years was the major contributing cause of the worsening of claimant's degenerative arthritic condition.

Dr. Noall offered a contrary opinion. He described claimant's condition as "idiopathic," adding that claimant's history suggested that the "condition probably began when [claimant] was in high school and, as expected in an osteoarthritic condition of this type, there has been a slow gradual progression over a period of about 20 years." He dismissed as "improbable" the view that claimant's work activities were a significant factor in the progression of the arthritic condition.

In view of the complex nature of claimant's foot problems, we accord greater weight to the opinion of the foot specialist. See Donald L. Oxford, 38 Van Natta 1297, 1299 (1986). Dr. Robertson is a podiatrist with a 10-year practice in

the treatment of foot diseases and surgical privileges at three local hospitals, while Dr. Noall practices in the broader field of orthopedics. Therefore, although both physicians' findings and conclusions appeared thorough and well-reasoned, we are most persuaded by those of the foot specialist and treating physician, Dr. Robertson.

We agree with the Referee's observation that Dr. Robertson's chart notes in 1985 bear no mention of a work relation. In fact, the only history taken of claimant's condition in 1985 was a notation entered during his first visit in October. At that time, Dr. Robertson noted that claimant had jumped down on his right heel two months earlier. We do not agree that the persuasiveness of Dr. Robertson's opinion is diminished to any degree. Dr. Robertson specifically recalled at hearing that, sometime during his follow-up check on claimant's orthotics (apparently in December 1985), he advised claimant to think about a job change because his condition would degenerate faster if he stood on his feet any longer. Indeed, claimant reported this advice to Dr. Noall in April, 1986. In any event, the dispositive question is whether there was a work relation, not when the relation was discovered.

Dr. Robertson identified the work activity of prolonged standing for many years as the major contributing cause of the worsening of claimant's degenerative arthritic condition. For the aforementioned reasons, we find this opinion persuasive and conclude that claimant has established the compensability of his condition.

ORDER

The Referee's order dated February 25, 1987 is reversed. The insurer's denial of the occupational disease claim for a bilateral foot condition is reversed and the claim is remanded to the insurer for processing according to law. Claimant's attorney is awarded a reasonable attorney fee of $1550 for services at hearing and $550 for services on Board review, to be paid by the insurer.

JOHN T. ELICKER, Claimant
Galton, et al., Claimant's Attorneys
SAIF Corp Legal, Defense Attorney
James E. Griffin, Assistant Attorney General

WCB TP-87031
May 3, 1988
Third Party Distribution Order

On February 19, 1988, we issued an Interim Order of Partial Distribution of the proceeds from a $6,358 third party settlement. See John T. Elicker, 40 Van Natta 68 (February 19, 1988). After claimant's attorney's fee, litigation costs, and statutory 1/3 share were deducted, his attorney was directed to reimburse the SAIF Corporation, as paying agency, for its actual claim costs of $861. We further ordered that the remaining balance of the settlement be held by claimant's attorney in trust, pending a final determination concerning the extent of claimant's permanent disability.

FINDINGS

Subsequent to the Board's order, the Evaluation Section of the Workers' Compensation Division reviewed claimant's back

injury claim. On March 8, 1988, a Determination Order issued, finding that claimant was neither entitled to temporary nor permanent disability compensation.

On April 5, 1988, claimant requested a hearing concerning the Determination Order. Shortly thereafter, he withdrew his request, asking that it be dismissed with prejudice. On April 22, 1988, the Referee issued an order, dismissing claimant's hearing request with prejudice.

CONTENTIONS

Asserting that the extent of his permanent disability arising out of his compensable injury has now been finally determined, claimant asks that the remaining balance of the proceeds from the settlement be distributed. Specifically, he requests that his attorney receive authorization to distribute the remaining balance to him. SAIF does not oppose this request, provided that claimant's hearing request concerning the Determination Order has been dismissed with prejudice.

CONCLUSIONS

Inasmuch as claimant's hearing request regarding the Determination Order has been dismissed with prejudice, we conclude that the extent of his permanent disability resulting from his compensable injury has been finally determined. Since it has been finally determined that claimant has sustained no permanent disability and because SAIF does not assert a lien for anticipated future expenditures, we hold that claimant is entitled to the remaining balance of the proceeds from the third party settlement. See ORS 656.593(1)(d).

Accordingly, claimant's attorney is directed to distribute the remaining balance of the proceeds from the third party settlement to claimant.

IT IS SO ORDERED.

LARRY R. GABBARD, Claimant
Malagon & Moore, Claimant's Attorneys
Foss, Whitty, et al., Defense Attorneys
Kate Donnelly (SAIF), Defense Attorney

WCB 87-07454 & 86-13512
May 3, 1988
Order on Review

Reviewed by Board Members Ferris and Crider.

The SAIF Corporation requests review of those portions of Referee Brown's order that: (1) set aside its denial of claimant's "new injury" claim for his current right knee condition; and (2) upheld an aggravation denial of the same condition, issued by Weyerhaeuser Company, a self-insured employer. We affirm.

ISSUE

Responsibility for claimant's current right knee condition.

FINDINGS OF FACT

Claimant sustained an injury on March 31, 1983 while employed by Weyerhaeuser as a timber faller, when he slipped off of a log and struck his right knee. His injuries were diagnosed as a torn

medial meniscus and a torn collateral ligament. Weyerhaeuser accepted the claim.

Claimant was off work for the next three years. During this period, he underwent four right knee surgeries. The final surgery was performed by Dr. James, orthopedic surgeon, on April 18, 1985. After one year of concentrated physical therapy, claimant underwent a physical capacities evaluation which placed his capabilities in the "very heavy" work category. He was highly motivated to return to work. Dr. James, who had originally been skeptical of claimant's his ability to return to his pre-injury employment, subsequently released him to his regular work.

Dr. Duff, orthopedic surgeon, performed an independent medical examination of claimant on April 23, 1986. He reported a very mild anterior and posterior cruciate laxity, with "1+" medial and lateral ligamentous laxity also. He, too, believed claimant was capable of returning to his regular work.

Claimant returned to work at Weyerhaeuser on May 5, 1986. He performed his job duties with minimal complaints. On June 9, 1986, claimant returned to Dr. James for a post-surgery closing examination. Dr. James noted mild residual posterior instability which he rated as a posterior drawer of 0 at 90 degrees flexion and a "1+" posterolateral instability.

Claimant continued to work at Weyerhaeuser until mid-June 1986 when a labor strike halted work activities. Claimant did not return to work at Weyerhaeuser.

A Determination Order issued on July 1, 1986 which awarded claimant 10 percent loss of use of his right leg (knee).

In August 1986, claimant went to work for SAIF's insured, which was owned and operated by his brother.

His job activities with SAIF's insured were less strenuous than those he performed while employed by Weyerhaeuser. Part of his time was spent falling and bucking trees, but he also spent time supervising cutting crews and conducting quality control activities.

On Janaury 30, 1987, claimant returned to Dr. James with complaints of increased pain, swelling and instability. However, claimant continued to work without time loss due to his knee condition. Dr. James' examination revealed a posterior drawer of "2+" at the 90 degree position and "1-2+" at the 30 degree position. This report was forwarded to Weyerhaeuser.

On March 6, 1987, Weyerhaeuser issued a denial of responsibility for claimant's right knee condition. SAIF issued a letter on May 5, 1987 which, inter alia, denied that claimant's employment with its insured was "the major contributing factor toward [his] development of right knee complaints."

Dr. James subsequently opined that claimant's employment with SAIF's insured caused a worsening of his underlying condition. He based that opinion upon the intensity and duration of claimant's reported work activities with SAIF's insured.

Claimant continued to work for his brother's company as of the date of hearing.

We find, based upon the content of his testimony, that claimant is not an entirely credible witness. Furthermore, based upon our de novo review of the medical and lay evidence, we find that claimant's work activities while employed by SAIF's insured independently contributed to a worsening of his underlying condition.

CONCLUSIONS OF LAW AND OPINION

In a successive injury case, responsibility rests with the second employer if work activities there independently contribute to a worsening of claimant's underlying condition. Hensel Phelps Const. v. Mirich, 81 Or App 290, 294 (1986). However, a worsening of symptoms alone is not enough to place responsibility on the second employer. There must be a worsening of the underlying condition. Id. Furthermore, it is the first employer's burden to prove that the later employment did, in fact, contribute to a worsening of the underlying condition. Eva L. (Doner) Staley, 38 Van Natta 1280 (1986). We conclude that Weyerhaueser has sustained that burden.

We find that assignment of responsibility for claimant's current knee condition is a complicated medical issue requiring expert medical opinion. Uris v. Compensation Department, 247 Or 420, 424 (1967). Dr. James is the only medical expert to express an opinion as to whether claimant's work activities for SAIF's insured independently contributed to a worsening of his underlying condition. Dr. James opined in the affirmative.

On review, SAIF asserts that the evidence fails to support either of the two related prerequisites needed to shift responsibility to the second employer: (1) an independent contribution; and (2) a worsening of the underlying condition. We first address the latter of these requirements, i.e., the need for proof of a worsening of the underlying condition.

In addition to pain and swelling, claimant suffers from knee instability. Dr. James' reports and deposition testimony establish that this instability results from ligamentous laxity. Comparing Dr. James' June 9, 1986 examination results with his January 30, 1987 examination results, we note an increase in claimant's right knee ligamentous laxity. SAIF argues that we should reject this evidence on the basis that Dr. James' method of testing for ligamentous laxity is "based on clinical feel and is not perfect." We decline to do so.

Dr. James explained that there is no way to test for ligamentous laxity other than through "clinical feel." He further explained that his analysis of the results of his clinical testing was based upon his twenty years of experience "stressing" knee joints. He concluded that his results represented objective findings of a worsened condition as of January 30, 1987. We are persuaded that claimant did, in fact, experience increased ligamentous laxity resulting in decreased right knee stability.

SAIF's primary contention is that claimant's work activities while employed by its insured did not independently contribute to the alleged worsened condition. Dr. James felt that there had been an independent contribution. SAIF asserts that we should reject Dr. James' opinion becauase it is based on an inaccurate history. Dr. James related in his January 30, 1987 report that claimant had returned to full work 7 days a week in the woods and that this work was "very strenuous." However, claimant testified that he spent only

a small portion of his workday engaged in strenuous activities. His testimony was supported by the testimony of his brother and that of a co-worker.

In this regard, the Referee found no reason to question any witnesses' credibility based on demeanor. He did find, however, that claimant's credibility was damaged by his admission that he provided false information to Dr. James regarding his condition on and prior to June 9, 1986. The Referee also discounted the testimony of claimant's brother on the basis that, as the owner of the second employer, he was a party in interest. We concur with the Referee's conclusions.

Claimant's co-worker also testified that claimant's work activities were of the less strenuous variety. The Referee found no reason to doubt the co-worker's testimony. We agree, but we nevertheless find the testimony to be of very limited value. This results from the fact that the co-worker testified that he observed claimant at work infrequently, sometimes going as long as two weeks without seeing claimant. It is, therefore, apparent that the co-worker could possess little first-hand knowledge of claimant's daily work activities.

In sum, we accept claimant's argument that his employment with SAIF's insured was less strenuous than that for Weyerhaeuser. However, we are not convinced that his level of exertion while employed by SAIF's insured was as moderate as that presented by the testimony.

We are not persuaded that Dr. James' conclusion regarding the reasons for claimant's ligamentous laxity should be given no weight as argued by SAIF. While the persuasiveness of Dr. James testimony is somewhat diminished by his reliance upon an inaccurate history, the fact remains that on June 9, 1986, one week prior to leaving Weyerhaeuser's employ, Dr. James reported a mild degree of right knee instability. Then, after five months of employment by SAIF's insured, Dr. James documented a worsening of that condition. We conclude that the evidence still preponderates on the side of an independent contribution to a worsening of claimant's condition resulting from claimant's employment with SAIF's insured.

Claimant's counsel is statutorily entitled to a reasonable, carrier-paid attorney fee for services rendered on Board review. See ORS 656.382(2). Such a fee is defined as an "assessed fee." OAR 438-15-005(2). However, we cannot authorize an assessed fee unless claimant's counsel files a statement of services. See OAR 438-15-1-1(5). Because no statement of services has been received to date, an assessed fee shall not be authorized.

ORDER

The Referee's order dated December 4, 1987 is affirmed. A client-paid fee to be paid by Weyerhaeuser Company, not to exceed $378, is approved.

FRANK A. HAMEL, Claimant
Meyers & Terrall, Defense Attorneys

WCB 86-14217
May 3, 1988
Order on Review

Reviewed by Board Members Ferris and Crider.

Claimant requests review of Referee Fink's order which upheld the self-insured employer's denial of his occupational disease claim for a hemorrhoidal condition. The sole issue is compensability.

We affirm the order of the Referee.

FINDINGS OF FACT

Claimant had worked as a bus driver for the employer since 1974. During the spring and summer of 1986, claimant worked on a bus route which allowed a six to eight-minute work break every one-half hour of his shift. These breaks generally provided him insufficient time for complete bowel movement, causing him to "push hard."

In July 1986, claimant developed hemorrhoidal symptoms, prompting him to file an occupational disease claim for "strain/potential hemorrhoids" allegedly resulting from having insufficient time during work breaks for adequate bowel movements. Later, he began to experience a swelling sensation along a "main artery" near his sex organs during sexual activities.

In early September 1986, claimant was transferred to a new bus route which allowed sufficient time for complete bowel movement during breaks. His symptoms have diminished since that time. The claim was denied on October 3, 1986.

At the time of hearing, there were no outstanding medical bills relating to this claim. Further, claimant has lost no time from work due to his hemorrhoidal condition.

There was insufficient evidence to support a finding that claimant's forced bowel movements at work were the major contributing cause of his hemorrhoidal condition, or its worsening.

CONCLUSIONS AND OPINION

The Referee upheld the denial, reasoning that claimant failed to establish a causal connection between his condition and employment and that his condition did not require medical services nor result in disability. We agree with the Referee's decision and rationale.

To establish compensability claimant must prove that work conditions were the major contributing cause of his condition, or its worsening, producing disability or the need for medical services. Dethlefs v. Hyster Co., 295 Or 298, 310 (1983); Weller v. Union Carbide, 288 Or 27, 35 (1979). The causation issue in this case presents a complex medical question. Hence, although claimant's testimony is probative, resolution of this issue largely turns on the medical evidence. Uris v. Compensation Department, 247 Or 420, 426 (1967); Kassahn v. Publishers Paper Co., 76 Or App 105, 109 (1985).

Here, the medical evidence weighs against compensabilty. Dr. Garnjobst performed an independent medical examination of claimant and opined that the hemorrhoidal condition was neither caused nor aggravated by employment conditions. Garnjobst explained that the hemorrhoids were "most likely" preexisting and that claimant's awareness of the condition had been heightened by his frustration in not having sufficient time for bowel evacuation. Dr. McCombe, claimant's family physician, concurred. There was no contrary medical evidence. Claimant challenged the medical evidence at hearing, testifying that he had never experienced hemorrhoidal symptoms prior to the spring of 1986. We are more persuaded by the medical evidence and find, therefore, that claimant's condition was neither caused nor worsened by employment conditions.

We are further persuaded that this condition neither required medical services nor resulted in any disability. Although claimant initially saw Dr. McCombe for the hemorrhoidal symptoms, there is no evidence in the record that McCombe either administered or recommended treatment for the condition. Dr. Garnjobst felt that no treatment was necessary. Indeed, claimant testified that there were no outstanding medical bills. Claimant further testified that he missed no time from work as a result of his condition. Based on the forgoing analysis, we conclude that the claimant's occupational disease claim for hemorrhoids is not compensable.

ORDER

The Referee's order dated June 15, 1987 is affirmed. A client-paid fee not to exceed $190 is approved.

JULIE E. JOHNSON, Claimant
Merrill Schneider, Claimant's Attorney

WCB 87-13332
May 3, 1988
Order on Review

Reviewed by Board Members Johnson and Ferris.

Claimant requests review of Referee Menashe's order that declined to assess penalties and attorney fees.

ISSUE

Whether penalties or attorney fees may be assessed against the self-insured employer for failing to timely comply with a Board order directing it to pay an assessed fee.

FINDINGS OF FACT

The parties stipulated to the following set of facts:

"1. The Workers' Compensation Board issued an Order on Review on June 24, 1987, in which it awarded Claimant's attorney $550.00 for services on board review, under ORS 656.382(2), and in which it affirmed the Opinion and Order. The Opinion and Order has awarded attorney fees of $900.00 on the denial of chiropractic care. A Circuit Court Judgment issued [sic] the award to $1100.00, or an increase of $200.00."

"2. These fees became payable and were due as a matter of law within thirty days of June 24, 1987, or on July 25, 1987."

"3. On, or about 8-19-87, [claimant's attorney's] office contacted [the employer's attorney] and indicated that the attorney fees were unpaid. In response to that call, the above fees, totalling $1,650 were paid to [claimant's attorney] as follows: A check for $550.00 was mailed on August 21, 1987, and an additional check for $212.37 was submitted on August 25, 1987. The extra $12.37 represented interest on the fees which were untimely paid. The amount of interest is not subject to dispute between the parties."

"4. [Claimant's attorney] requested a hearing for failure to timely pay the attorney fees. He requests penalties and late fees."

CONCLUSIONS OF LAW

Pursuant to ORS 656.262(10), when an employer/insurer unreasonably refuses to pay compensation it shall be liable for a penalty plus any attorney fees assessable under ORS 656.382. ORS 656.382 provides, in part:

"(1) If an insurer or self-insured employer refuses to pay compensation due under an order of a referee, board or court, or otherwise unreasonably resists the payment of compensation, the employer or insurer shall pay to the claimant a reasonable attorney fee . . . ."

"Compensation" is defined by ORS 656.005(9) as "all benefits, including medical services provided for a compensable injury to a subject worker . . . ."

Relying on the above statutes and the case of Mobley v. SAIF, 58 Or App 394 (1982), the Referee concluded that no penalty or attorney fee could be assessed against the employer for its late payments of claimant's assessed fee. We affirm, although we find the Referee's reliance on Mobley misplaced.

In Mobley, the court: (1) affirmed that portion of the Board's order that modified the Referee's award of an attorney fee from $1,100 to $600; and (2) reversed and remanded that portion of the order that failed to award claimant's attorney a fee under ORS 656.382(2) for successfully defending the compensability of claimant's groin injury claim on Board review.

The issue presently before us is whether penalties and attorney fees may be assessed against the employer for its failure to timely comply with a prior Board order directing it to pay an assessed fee. Mobley did not address that issue and, therefore, is not applicable to present case.

We agree with the Referee, however, that claimant is not entitled to either a penalty or attorney fee. ORS 656.262(10) provides for a penalty and attorney fee when an employer/insurer unreasonably delays or refuses to pay "compensation." Similarly, ORS 656.382(1) provides for an attorney fee when an employer/insurer refuses to pay or otherwise unreasonably resists the payment of "compensation." The definition of "compensation" in ORS 656.005(9) refers to "all benefits . . . provided for a compensable injury to a subject worker."

Here, the Board-ordered assessed fee did not concern a "benefit" to claimant; but rather, a fee to his attorney. In Dotson v. Behemia, Inc., 80 Or App 233, 236 (1986), the court interpreted the term "benefit" in ORS 656.005(9) narrowly, stating, in part:

> "We think that the legislature intended "benefits . . . provided for a compensable injury" to refer to those set forth in ORS 656.202 to ORS 656.258."

The court, therefore, rejected an argument that claimant's attorney was entitled to a fee under ORS 656.382(2) for protecting a fee award on Board Review. Accordingly, we conclude that the Referee was correct in declining to assess either a penalty or attorney fee given the particular facts of the present case.

ORDER

The Referee's order dated January 4, 1988 is affirmed.

DONALD J. KUNKLER, Claimant
Myrick, Coulter, et al., Claimant's Attorneys
Cowling & Heysell, Defense Attorneys
Foss, Whitty, et al., Defense Attorneys

WCB 87-01470 & 86-16858
May 3, 1988
Order on Review

Reviewed by Board Members Ferris and Crider.

Liberty Northwest Insurance Corporation, on behalf of its insured, Gregory Forest Products, requests review of Referee Leahy's order that: (1) set aside its denial of claimant's aggravation claim for a low back and hip condition; and (2) upheld a denial of claimant's "new injury" claim for the same condition issued by Liberty Northwest, on behalf of its insured, Reddaway Truck Lines. We affirm.

ISSUE

On review, the issue is responsibility.

FINDINGS

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

Claimant credibly testified regarding his symptomatic history and work activities.

At the time of claimant's initial injury in December 1985, Gregory Forest Products was insured by Liberty. Following that

injury, Dr. Welch diagnosed mid lumbar strain and sprain. Claimant received conservative treatment. His injury claim was accepted and subsequently closed with no award of permanent disability.

Claimant has never returned to the type of heavy labor he performed at the time of his 1985 injury. Since claim closure, he has continued receiving chiropractic treatment for intermittent back and hip pain. One of these symptomatic flare-ups occurred in October 1986 during a three-week job for Reddaway Truck Lines, also insured by Liberty. This flare-up was similar to previous symptomatic exacerbations and was not associated with any particular work injury or activity. Following this flare-up, Dr. Welch made an additional diagnosis of secondary myofibrocitis.

Claimant continued to experience symptomatic exacerbations and his right hip became increasingly painful. He subsequently filed claims with both Gregory Forest Products and Reddaway Truck Lines and both claims were denied.

After de novo review of the record, we find that Dr. Welch's additional diagnosis of secondary myofibrocitis reflected the chronic nature of claimant's condition, rather than any material change due to his employment with Reddaway Truck Lines. Moreover, we are not persuaded that claimant's employment with Reddaway Truck Lines independently contributed to a worsening of his underlying back and hip condition.

CONCLUSIONS AND OPINION

We affirm the Referee's order with the following comment.

Cases involving successive injuries and successive insurance carriers are decided under the "last injurious exposure" rule. Boise Cascade v. Starbuck, 296 OR 238 (1984). Under this rule, responsibility rests with the carrier at risk at the time of the most recent injury that independently contributed to a worsening of the claimant's underlying condition. Hensel Phelps Construction v. Mirich, 81 Or App 290 (1986); Smith v. Ed's Pancake House, 27 Or App 361 (1976).

In the present case, Liberty, as insurer for Gregory Forest Products, remains responsible for claimant's back and hip condition unless it demonstrates that claimant's later employment with Reddaway Truck Lines independently contributed to a worsening of claimant's condition.

However, a worsening of symptoms, alone, will not shift responsibility to the subsequent employer, even if the increased symptoms result in disability. Spurlock v. International Paper, 89 Or App 461 (1988); Hensel Phelps Construction v. Mirich, supra; James River Corp. v. Youngblood, 80 Or App 472 (1986). The absence of a specific trauma during the second employment weighs in favor of keeping responsibility with the first employer, but it is not dispositive. Hensel Phelps Construction v. Mirich, supra. For example, responsibility will not shift to a subsequent employer where a claimant has suffered a back strain, followed by a period of work with continuing symptoms indicating that the original condition persists, and culminating in a second period of disability precipitated by some lift or exertion. See Hensel Phelps Construction v. Mirich, supra.

As discussed above, we are not persuaded that claimant's employment with Reddaway Truck Lines independently contributed to a worsening of his underlying condition. Claimant's back and hip symptoms continued after his initial back strain with Gregory Forest Products. His subsequent symptomatic exacerbation with Reddaway Truck Lines was not associated with any specific trauma. Moreover, the record contains no objective evidence of a worsening of claimant's condition as a result of that employment. Finally, Dr. Welch's additional diagnosis of secondary myofibrocitis reflected the chronic nature of claimant's condition rather than any material change associated with his employment with Reddaway Truck Lines.

Accordingly, responsibility for claimant's condition remains with Liberty, as insurer for Gregory Forest Products. See Hensel Phelps Construction v. Mirich, supra.

ORDER

The Referee's order dated June 30, 1987 is affirmed. The Board approves a client-paid fee for services on Board review for the attorney for Liberty Northwest Insurance Corporation, as insurer for Reddaway Truck Lines, not to exceed $595. The Board also approves a client-paid fee for services on Board review for the attorney for Liberty, as insurer for Gregory Forest Products, not to exceed $160.

ROBERT L. MURPHY, Claimant
Quintin B. Estell, Claimant's Attorney
Rick Dawson (SAIF), Defense Attorney

WCB 86-06489
May 3, 1988
Order on Review

Reviewed by Board Members Ferris and Crider.

Claimant requests review of Presiding Referee Daughtry's order which dismissed his hearing request. We reverse and direct that the hearing request be reinstated.

FINDINGS OF FACT

On May 9, 1986, claimant requested a hearing on a Determination Order. The issues raised in the request were temporary total disability, permanent partial disability, medical services and premature claim closure. Claimant's claim was subsequently reopened for surgery and, on December 9, 1986, claimant's attorney wrote to the Board, requesting that the case be placed in inactive status until claim closure. The case was placed in inactive status until September 9, 1987. On August 21, 1987, the SAIF Corporation filed its response to the hearing request, denying all contentions raised in the request.

On September 10, 1987, claimant's attorney wrote Presiding Referee Daughtry, requesting that the case remain in inactive status pending claim closure. The case was again placed in inactive status until December 14, 1987.

On November 30, 1987, claimant's attorney wrote Referee Daughtry, requesting that the hearing request be dismissed "with the right to preserve all issues until this claim has been closed and is ready to proceed to hearing." Claimant's attorney also requested that SAIF's attorney prepare a stipulation if there was no objection to the request for dismissal. SAIF's attorney raised no objection to the dismissal request, but prepared no stipulation. On December 14, 1987, Referee Daughtry entered an

order of dismissal, noting that the hearing request had been withdrawn. The order did not specify whether the dismissal was "with prejudice" or "without prejudice."

CONCLUSIONS AND OPINION

On review, claimant contends that the Referee's dismissal order should be modified to read that it was issued "without prejudice." We decline to do so for two reasons. First, it is our policy to interpret any dismissal order issued by the Hearings Division as an order of "dismissal without prejudice," unless the order states otherwise. Consequently, modification is unnecessary.

In any event, the requested modification would have little effect on claimant's hearing rights because the one-year limitations period for filing a request for hearing on the Determination Order has passed. See former ORS 656.319(4). Thus, although the modification would ensure that the dismissal order itself does not preclude another request for hearing on the Determination Order any such hearing request would be precluded by the statute of limitations. If we dismiss without prejudice, claimant will be unable to contest the Determination Order award of temporary total disability compensation. Moreover, although claimant could litigate the issue of permanent partial disability after the issuance of a new Determination Order, he would have the burden of proving that he has become more disabled since the first Determination Order, because the first Determination Order will be final and the law of the case. See Stepp v. SAIF, 78 Or App 438, 441-42 (1986).

We do not interpret claimant's November 30, 1987 letter to the Referee as a request for an order of "dismissal without prejudice." Rather, claimant sought to have his case taken off the docket while preserving his right to litigate the issues arising from the first Determination Order. Claimant's hearing rights would have been preserved if his case had remained in inactive status. As a matter of Board policy, a request for hearing on a Determination Order should not be dismissed when the issue of permanent partial disability cannot be litigated because claimant is no longer medically stationary.

Accordingly, we reverse the Referee's order of dismissal, and reinstate the claimant's hearing request. If the claim is no longer open, the case may be scheduled for hearing. If the claim remains open, the hearing may be deferred under the Board rules. This case is remanded to the Hearings Division for further action consistent with this order.

ORDER

The Referee's dismissal order dated December 14, 1987 is reversed. Claimant's hearing request dated May 9, 1986 is reinstated.

MERRICK L. NEILL, Claimant
Velure & Yates, Claimant's Attorneys
E. Jay Perry, Defense Attorney

WCB 87-12535
May 3, 1988
Order on Review

Reviewed by Board Members Crider and Ferris.

The insurer requests review of those portions of Referee Baker's order that: (1) awarded claimant 20 percent (64 degrees) unscheduled permanent partial disability for his low back condition whereas a Determonation Order had awarded no permanent disability; (2) set aside its partial denial of claimant's weight loss program; and (2) assessed penalties and attorney fees for an unreasonable denial. On review the issues are extent, compensability and penalties and attorney fees.

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

The insurer contends that no attorney fees can be assessed against it except under ORS 656.382. It argues that since this case did not arise from a refusal to pay compensation under an order of a Referee, Board or court, an attorney fee is only justified if it unreasonably resisted payment of compensation under ORS 656.382(1).

The insurer is incorrect for ORS 656.382 is not the sole authority for award of a carrier-paid fee. In this case, claimant prevailed in his effort to overcome the insurer's denial of a claim for medical services and the insurer's premature denial of surgery. ORS 656.245(2) provides for the filing of claims for medical services. Such services are compensation. ORS 656.005(8). Having overcome the insurer's denial of compensation, claimant is entitled to an insurer-paid fee under ORS 656.386(1). See e.g. Aguiar v. J.R. Simplot Co., 87 Or App 475 (1987); Lloyd L. Eddings, 38 Van Natta 1478 (1986).

The Referee ordered an insurer-paid attorney fee of $800. Although he does not cite ORS 656.386(1), this statute does support his action. Consequently we affirm his order.

Claimant's counsel is statutorily entitled to a reasonable, carrier-paid attorney fee for services rendered on Board review. See ORS 656.382(2). Such a fee is defined as an "assessed fee." OAR 438-15-005(2). However, we cannot authorize an assessed fee unless claimant's counsel files a statement of services. See OAR 438-15-010(5). Because no statement of services has been received to date, an assessed fee shall not be authorized.

ORDER

The Referee's order dated December 2, 1987 is affirmed. The Board approves a client paid fee not to exceed $876.

SIMON Z. RENDON, Claimant
Vick & Gutzler, Claimant's Attorneys
John Motley (SAIF), Defense Attorney

WCB 87-03782
May 3, 1988
Order on Review

Reviewed by Board Members Crider and Johnson.

Claimant requests review of Referee Peterson's order that upheld the SAIF Corporation's denial of his aggravation claim for his current upper back, low back, and right shoulder conditions. On review, the issue is aggravation. We affirm.

FINDINGS OF FACT

In 1980 claimant injured his low back and right leg while working on a farm. In 1981 he injured his neck and reinjured his low back. These claims were accepted. In 1982 by stipulation and order, he received 35 percent permanent disability for his low back. In August 1986 he was awarded an additional 5 percent permanent disability for his right arm.

On November 18, 1986, Dr. Knox, neurologist, ordered a complete workup and tests for claimant. These tests were completed before the last arrangement of compensation.

A hearing was held on November 19, 1986. The issue at that hearing was extent of permanent disability. No additional disability was awarded.

On January 7, 1987, Dr. Knox wrote to Dr. Moore, claimant's treating chiropractor, to inform him of his findings and opinions.

On February 26, 1987, Dr. Martins, orthopedic surgeon, examined claimant.

On March 4, 1987, the insurer denied claimant's request to reopen his claim for aggravation on the basis that it did not think his condition had worsened.

Claimant's condition has not worsened since his November 19, 1986 hearing which constitutes the last arrangement of compensation.

CONCLUSIONS OF LAW AND OPINION

Claimant contends he suffered an aggravation based on the findings and opinion derived from Dr. Knox's November 18, 1986 examination and tests.

Alternatively, claimant contends that since an aggravation can be proved by either lay or medical evidence, his testimony is sufficient to prove he has suffered an aggravation since his last award of compensation.

In order to establish a claim for aggravation, claimant must prove a worsening of his condition since the last arrangement of compensation. ORS 656.273(1). The only evidence to support a worsening of claimant's condition since November 19, 1986 is his testimony that he suffers more symptoms as well as symptoms in new areas.

Dr. Knox's findings and opinion do not support claimant's contention that he has suffered an aggravation because they do not relate any worsening of claimant's condition to a time period after November 19, 1986.

The Referee concluded that claimant failed to present evidence that his condition worsened since the last arrangement of compensation which occurred on November 19, 1986. We agree.

Dr. Martins examined claimant after the last arrangement

of compensation. His examination revealed that there had been no change in claimant's functional impairment since claim closure in August 1986.

It is claimant's burden to prove that he has incurred an additional loss of earning capacity due to intensified old symptoms or new symptoms. Van Woesik v. Pacific Coca-Cola Co., 85 Or App 9 (1987). Claimant's testimony fails to prove a loss of earning capacity.

Consequently, the lay and medical evidence does not establish that claimant suffered an aggravation of his condition.

ORDER

The Referee's order dated June 1, 1987, as reconsidered June 12, 1987, is affirmed.

FRANK A. VILANJ, Claimant
Schwabe, et al., Defense Attorneys

WCB 87-12285
May 3, 1988
Order on Review

Reviewed by Board Members Johnson and Ferris.

Claimant, pro se, requests review of Referee Podnar's order that: (1) upheld the self-insured employer's denial of his aggravation claim for a neck and shoulder condition; and (2) declined to award additional permanent partial disability. On review the issues are aggravation and, in the alternative, extent.

The Board affirms the order of the Referee.

FINDINGS OF FACT

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

On October 16, 17 and 23, 1987, a private investigator made a surveillance film of claimant showing him lifting a 35-pound propane tank out of a camper and placing a 20-pound wood box in the camper. The film also shows claimant walking and moving with no restriction.

On November 17, 1987, the employer issued its denial of claimant's aggravation claim.

CONCLUSIONS OF LAW AND OPINION

Claimant contends he has suffered an aggravation of his neck and shoulder condition.

Claimant must prove that his condition has worsened in order to establish a compensable aggravation. Georgia Pacific Corp. v. Roff, 80 Or App 78, rev den, 301 Or 666 (1986). Although symptoms in themselves are not compensable as an aggravation, pain that results in additional loss of earning capacity is. Van Woesik v. Pacific Coca-Cola Co., 88 Or App 9 (1987).

Claimant reinjured his neck in January 1986. As of February 1986, the doctors regarded his pain complaints as out of proportion to the physical findings.

Following claim closure in June 1987, claimant returned to his work as a truck driver. He quit this job for nonmedical reasons and began working for a different company as a long haul truck driver.

On September 11, 1987, Dr. Irvine, orthopedist, opined claimant could not tolerate long haul driving because of the prolonged sitting and head turning the job required. However, claimant left a retraining program in mechanics to return to truck driving.

Dr. Silver, neurologist, examined claimant and found no objective evidence of physical abnormalities.

On October 23, 1987, the Orthopaedic Consultants examined claimant. They found no evidence of atrophy of fasciculation and noted that the calluses on claimant's hands indicated he was using both to do heavy work.

On December 7, 1987, Dr. Irvine opined that claimant had not suffered an aggravation and assessed his impairment as mildly moderate.

Claimant began treating with Dr. Kemple, rheumatologist. Dr. Kemple believed that further diagnosis was necessary. He opined that claimant demonstrated a possible pathogenic overlap from an abnormal connective tissue response profile and some brachial plexus impingement. He felt claimant was prominently impaired. Dr. Kemple authorized time loss for an indefinite period.

The Referee found claimant's assessments of a worsened condition not persuasive because the majority of physicians had found his complaints out of proportion to the objective findings and because he found claimant was not a credible witness. We agree.

We generally defer to the Referee's determination of credibility and reliability due to the Referee's opportunity to observe the witness. Timothy J. Swodeck, 39 Van Natta 341 (1987). Furthermore, the fact that claimant demonstrated a pattern of returning to strenuous work such as truck driving and leaving due to nonmedical reasons rather than physical complaints of pain, lends support to the persuasiveness of the medical opinions that found claimant suffered no aggravation of his condition. Consequently, we find claimant has failed to prove that his condition has worsened or that he has incurred a loss of earning capacity due to pain.

Claimant contends, in the alternative, that his award of 20 percent (64 degrees) permanent partial disability is inadequate.

The Referee reasoned that the medical findings, the surveillance film and the fact that claimant consistently returned to strenuous work, are inconsistent with a determination that claimant is entitled to additional compensation. We agree.

ORDER

The Referee's order dated December 30, 1987 is affirmed.

Robin O. Donaldson, Claimant
Flaxel, Todd, et al., Claimant's Attorneys
Foss, et al., Defense Attorneys

WCB 87-07005
May 5, 1988
Order on Review

Reviewed by Board Members Crider and Ferris.

Claimant requests review of those portions of Referee Quillinan's order that affirmed a Determination Order that awarded 20 percent (30 degrees) scheduled permanent partial disability for loss of use or function of the left leg (knee) and no unscheduled permanent disability for claimant's low back condition. We modify in part and affirm in part.

ISSUES

1. Extent of scheduled disability for claimant's left leg (knee).

2. Extent of unscheduled disability, if any, for claimant's low back.

FINDINGS OF FACT

The Board adopts the Referee's Findings of Fact with the following additions. We find that claimant's level of left leg impairment resulting from his compensable January 18, 1985 injury is moderate. In addition, we find that claimant has suffered no low back impairment as a result of the compensable injury.

CONCLUSIONS OF LAW AND OPINION

Scheduled Left Leg (Knee) 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. ORS 656.214(2). Guidelines to assist in the determination of the extent of permanent disability caused by a leg (knee) injury are set forth in OAR 436-30-330 and 436-30-340. 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).

Claimant's treating orthopedist, Dr. Bert, opined that claimant's left leg impairment is moderate. BBV Medical Consultants reported that claimant's impairment was mild. Absent persuasive reasons to the contrary, the treating physician's opinion is generally entitled to greater weight. Weiland v. SAIF, 64 Or App 810 (1983). Dr. Bert's impairment rating is supported by the evidence. We, therefore, conclude that claimant's left leg impairment is moderate. In addition to disabling pain, claimant suffers from knee joint instability and has undergone two medial menisectomies, one partial and one total.

Following our de novo review of the medical and lay evidence, we conclude that an award of 30 percent scheduled permanent disability adequately and appropriately compensates claimant for the permanent loss of use or function of his left leg (knee). We, therefore, increase the award granted by the Referee by 10 percent.

Unscheduled (Low Back) Disability

The criteria for the rating of unscheduled disability is the permanent loss of earning capacity due to the compensable injury. ORS 656.214(5). It is claimant's burden to prove that he has incurred a permanent loss of earning capacity as a result of the January 18, 1985 injury. Hutcheson v. Weyerhaeuser Co., 288 Or 51, 56 (1979). Claimant has failed to do so.

Claimant argues on review that he is now unable to drive certain categories of trucks that he was previously capable of driving, e.g. "cabover-type" of trucks. The record establishes, however, that claimant's restrictions are solely related to the disabling aspects of his knee injury. As of the date of hearing, claimant's low back condition was not disabling and had not resulted in any loss of earning capacity. Therefore, we conclude that claimant is not entitled to an award of unscheduled permanent disability.

ORDER

The Referee's order dated December 29, 1987 is affirmed in part and modified in part. In addition to the Determination Order's award of 20 percent (30 degrees) scheduled permanent disability, claimant is awarded 10 percent (15 degrees) scheduled permanent left leg (knee) disability, for a total award to date of 30 percent (45 degrees). The remainder of the Referee's order is affirmed. Claimant's attorney is awarded 25 percent of the increased compensation granted by this order as an attorney fee. However, the total attorney fees allowed by the Referee and this order shall not exceed $3,000. The Board approves a client-paid fee not to exceed $280.

RICHARD A. LUNA, Claimant
Black, Chapman & Webber, Claimant's Attorneys
Schwabe, et al., Defense Attorneys

WCB 87-03680
May 5, 1988
Order on Review

Reviewed by Board Members Crider and Ferris.

Claimant requests review of Referee Borchers' order which upheld the self-insured employer's denial of his medical services claim for left shoulder arthroscopic acromioplasty surgery. The sole issue is medical services. Claimant did not file a brief on review. We affirm.

FINDINGS OF FACT

Claimant compensably injured his left arm and shoulder in November 1983 when he slipped and fell. The claim was closed with no permanent disability award. However, claimant continued to experience left shoulder pain which was related to the industrial injury.

In October 1986, Dr. Chamberlain, an orthopedist, diagnosed left shoulder impingement syndrome and recommended ultrasound therapy. In November 1986, Chamberlain offered claimant the option of an arthroscopic acromioplasty to relieve the shoulder pain. Claimant agreed to undergo surgery.

In January 1987, Chamberlain's request for authorization of surgery was denied on grounds that surgery was not reasonable and necessary and was not related to work activities.

Arthroscopic surgery was performed on the left shoulder by Dr. Chamberlain in August 1987. All findings in Chamberlain's surgery report were normal. The left shoulder pain resolved fully in October/November 1987.

We find that the surgery was not curative. In addition, there was insufficient evidence to support a finding that surgery resulted in any material palliative benefit. We find that surgery was neither reasonable nor necessary.

CONCLUSIONS AND OPINION

The Referee upheld the denial, concluding that the surgery was not reasonable and necessary to the process of claimant's recovery from the compensable injury. We agree.

Claimant is entitled to medical services for conditions resulting from his compensable injury so long as the nature of the injury or process of the recovery requires. See ORS 656.245(1). He has the burden of proving that medical services were reasonably and necessarily incurred in the treatment of his compensable injury. See James v. Kemper Ins. Co., 81 Or App 80, 84 (1986).

The medical evidence in this case is divided. By a check-the-box response, Dr. Chamberlain, claimant's treating orthopedist, agreed that the surgery was reasonable and necessary. On the other hand, Dr. Laubengayer, an orthopedist who saw claimant on approximately five occasions between February 1985 and February 1986 and reviewed his medical records, opined that the surgery was neither reasonable nor necessary. Laubengayer explained that arthroscopic shoulder surgery was a mere "searching" procedure which was unlikely to yield anything in this case.

We generally give greater weight to the treating physician's opinion, absent persuasive reasons not to do so. See Weiland v. SAIF, 64 Or App 810, 814 (1983). We find persuasive reasons not to give Dr. Chamberlain's opinion greater weight in our determination.

Chamberlain's opinion is conclusory; he fails to explain why the surgery was reasonable and necessary. Our review of Chamberlain's medical reports suggests that surgery was recommended simply because other treatments were unsuccessful and claimant felt he had "nothing to lose" by undergoing surgery. Chamberlain acknowledged that the surgery would not be curative, and he never explained what, if any, material palliative benefit would be obtained through surgery. Although claimant's shoulder pain eventually resolved approximately two months after surgery, there was no evidence that surgery contributed to this pain relief. For the forgoing reasons, we are most persuaded by the well-reasoned opinion of Dr. Laubengayer. See Somers v. SAIF, 77 Or App 259, 263 (1986). We conclude that the left shoulder surgery was not reasonable and necessary and, therefore, not compensable.

The self-insured employer's counsel seeks Board authorization of a client-paid fee for services rendered on Board review. We cannot authorize the fee unless the employer's counsel files a statement of services and an executed attorney retainer

agreement. OAR 438-15-010(1), 438-15-010(5). No attorney retainer agreement has been received to date. Furthermore, the statement of services submitted by the employer's counsel identifies the issue on Board review as "[e]ntitlement to reimbursement for travel expenses," which apparently refers to another case involving these parties which is presently pending review. Here, the sole issue on review is medical services. Consequently, we cannot authorize a client-paid fee.

ORDER

The Referee's order dated December 28, 1987 is affirmed.

ANGELINE C. MARTIN, Claimant
Michael Brant, Claimant's Attorney
Arthur Stevens (SAIF), Defense Attorney

WCB 87-00076
May 5, 1988
Order on Review

Reviewed by Board Members Ferris and Crider.

Claimant requests review of Referee Shebley's order which upheld the SAIF Corporation's denial of her claim for a left great toe condition. The sole issue is compensability. We affirm.

FINDINGS OF FACT

Claimant, a bookkeeper, injured her left great toe on July 22, 1986 when she stubbed it against the leg of a desk at work. Although the toe hurt, claimant did not believe there was any serious damage done. She apparently did not miss any time from work and did not seek medical care. Her toe pain subsequently diminished. About a month later, claimant developed pain at the tip of her left great toe. A ridge had developed on the toenail and claimant found it painful to wear closed-toed shoes.

On August 22, 1986, claimant saw Dr. Lehrburger with complaints of increasing left toe pain and sensitivity. He initially diagnosed probable great toe hematoma and possible fungal infection. He later changed the diagnosis to left great toe pain, etiology unknown.

Lehrburger referred claimant to Dr. Warren, an orthopedist. Warren noted a little fungus growing under the nail and tenderness at the tip of the toe. He was also unable to determine the etiology of the toe pain. He suspected that claimant had an inflammatory process. He took claimant off work in September 1986.

Claimant filed her claim for left great toe pain in August 1986. SAIF denied the claim in December 1986, citing insufficient evidence that the condition was the result of either an occupational injury or disease.

We are unable to find that the July 1986 stubbing incident was a material contributing cause of claimant's painful toe condition.

CONCLUSIONS AND OPINION

The Referee upheld SAIF's denial, citing insufficient evidence that the painful toe condition was causally related to the July 1986 stubbing incident. We agree.

Claimant bears the burden of proving by a preponderance of the evidence that an industrial injury materially contributed to her disability or need for medical treatment. Hutcheson v. Weyerhaeuser, 288 Or 51, 56 (1979); Milburn v. Weyerhaeuser Company, 88 Or App 375, 378 (1987).

Although claimant clearly experienced a painful great toe as a result of the July 1986 stubbing incident, there was no evidence that claimant's current disability and need for medical treatment were attributable to that particular pain condition. Rather, it was at least equally likely that claimant's current disability and need for treatment were attributable to pain resulting from toe fungus, ridge, or suspected inflammatory process. That is to say, we are not persuaded that the toe pain which resulted from the stubbing incident was related to the painful toe condition for which this claim was filed. There was no medical evidence that the stubbing incident was a material contributing cause of the fungus, ridge, or suspected inflammatory process. In the absence of medical evidence of a causative link, we decline to infer causation from mere chronological sequence. See Bradshaw v. SAIF, 69 Or App 587, 589 (1984). We do not find, therefore, that the July 1986 stubbing incident was a material contributing cause of claimant's painful toe condition for which she sought treatment on August 22, 1986. Given the absence of a work relation, we conclude that her claim was not compensable.

ORDER

The Referee's order dated August 13, 1987 is affirmed.

EDGAR JASON KNAPP, Applicant
Ann Kelley, Assistant Attorney General

WCB CV-87009
April 8, 1988
Crime Victim Order

Applicant has requested review by the Workers' Compensation Board of Findings of Fact, Conclusions and an Order on Reconsideration issued by the Department of Justice Crime Victim Compensation Program ("Department") dated November 24, 1987. By its order, the Department denied applicant's claim for compensation as a victim of a crime under ORS 147.005 to 147.365. The Department based its denial on its finding that applicant was not the victim of a compensable crime.

Following our receipt of the request for review, applicant was advised that he was entitled to a fact finding hearing before a Special Hearings Officer. To exercise his right to a hearing, applicant was instructed to notify the Board within 15 days from the date the Department mailed his copy of its record. The Department mailed a copy of its record to applicant on December 17, 1987. Having received no hearing request, we have conducted our review based solely on the written record. See OAR 438-82-030(2).

The standard for our review under the Act is de novo, based on the entire record. ORS 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.

FINDINGS

In June 1987, applicant filed this claim on behalf of his 3-year old son, Edgar Jason Knapp. Applicant contended that, on May 16, 1987, his son was the innocent victim of the unprovoked crime of driving while suspended.

A police traffic accident report was obtained. Applicant advised Officer Urban, the investigating officer, that he was crossing the street with his son when a vehicle turned onto the street "at a real high rate of speed" and ran over his son. An investigation at the scene revealed that the driver of the vehicle was Darrell Raffety.

According to the report, Raffety stated that he had just turned left onto a street from an intersecting street when he observed a man (later determined to be applicant) standing on the curb waving his arms. As Raffety's attention returned to the street, he saw a small child in front of his car. Contending that he had no time to brake or otherwise avoid hitting the child, Raffety admitted that his vehicle struck the child. Raffety further surmised that his vehicle was travelling less than 15 miles per hour at impact.

Two independent witnesses agreed that Raffety's vehicle was travelling at approximately 15 to 20 miles per hour when it struck the child. They also stated that the child was standing in the middle of the street. Officer Urban was unable to find skid marks, broken glass, or blood in the street. Raffety was cited for Driving While Suspended, Driving Uninsured, and Careless Driving. At the time of the Department's initial determination, these matters remained pending before the traffic court.

At the Department's request, Officer Urban submitted a letter further describing the investigation. Urban reported that Raffety and the two independent witnesses had stated that the child was left standing unattended in the middle of the street prior to being struck. In addition, the witnesses advised Urban that the child was neither standing in a crosswalk nor intersection when struck by the center of the vehicle. Officer Urban explained that the charge of careless driving stemmed from Raffety's failure to watch the road as he turned to see applicant waving. Urban did not consider this action to constitute reckless driving.

Based on the witnesses' statements, Urban found that the driver had stopped within one and one-half car lengths after impact. This finding was further supported by Urban's inability to locate either skid marks, broken glass, or blood at the scene. Thus, there was neither a corroborating witness nor physical evidence to substantiate applicant's contention that the speed of Raffety's vehicle was excessive. Finally, if applicant had been standing next to his son prior to impact as he contended, Urban reasoned that applicant would have also been hit since the child was struck with the center of the car. Consequently, it was Urban's conclusion that the contributing factor to the accident was the minor child's unattended presence in the middle of the street.

As a result of the accident, Jason sustained the following injuries: contusion and laceration of the right kidney;

contusion of the right lobe of the liver with hematoma; delayed rupture of the liver; cerebral concussion; multiple abrasions; and laceration of the right forehead. The treatment for these injuries has generated medical bills which currently exceed $37,000.

Following its investigation, the Department found that the accident was not the result of an intentional, knowing or reckless act which would be punishable as a crime in the State of Oregon. Thus, the Department concluded that the child was not the victim of a "compensable crime" as defined in ORS 147.005(4). Accordingly, applicant's claim for compensation was denied.

Applicant requested reconsideration, asserting that he was in the best position to observe the scene. Stating that, at the time of the accident, he had been instructing his son concerning the proper method to follow when crossing a street, applicant insisted that they had looked both directions before his son had proceeded across the street. Furthermore, applicant contended that Raffety's act of driving a motor vehicle without insurance and knowing that his license had been suspended constituted a "knowing" action as required by the statute. Finally, applicant noted that Raffety had pleaded guilty to the charges, but while awaiting sentencing had fled from the state.

On November 24, 1987, the Department reconsidered its prior order. Following further investigation, the Department found no basis for reversing its original order. Thereafter, applicant requested Board review.

CONCLUSIONS

Pursuant to ORS 147.015, applicant, on behalf of his son, is entitled to an award under the Compensation of Crime Victims Act (Act), if, among other requirements:

> "(1) [He] is a victim, or is a dependent of a deceased victim of a compensable crime that resulted in a compensable loss of more than $250."

A "compensable crime" means an intentional, knowing or reckless act that results in serious bodily injury or death of another person and which, if committed by a person of full legal capacity, would be punishable as a crime in this state. ORS 147.005(4). "Intentional" is defined as an act with a conscious objective to cause the result or to engage in the conduct described. ORS 161.085(7). "Knowing" means that a person acts with an awareness that his/her conduct is of a nature so described or that a circumstance so described exists. ORS 161.085(8). "Reckless" is defined as an act where the person is aware of and consciously disregards a substantial and unjustifiable risk that the result will occur or the circumstance exists. ORS 161.085(9). The risk must be of such nature and degree that the disregard thereof constitutes a gross deviation from the standard of care that a reasonable person would observe in the situation. id.

On de novo review of the record, we find that applicant was not the victim of a compensable crime. Accordingly, we conclude that the Department's Order on Reconsideration should be affirmed.

Applicant asserts that the driver's conduct was reckless in operating his vehicle at an excessive speed and failing to keep a proper lookout. In support of this contention, he draws from his observations at the scene. We acknowledge that applicant was in an advantageous position to observe the accident. Yet, the remaining witnesses, including two disinterested bystanders, as well as the physical evidence at the scene, persuasively establish that Raffety's actions in striking the child with his vehicle were neither knowing, intentional, nor reckless.

Instead, the evidence supports the conclusion that the child's injuries resulted from the unfortunate combination of his unattended presence in the middle of the street and the driver's careless driving. Careless driving is a Class B infraction. ORS 811.135. As such, it is not a crime in this state as required by ORS 147.015(1).

Applicant further contends that the driver's operation of his vehicle, knowing that he neither had insurance nor a valid license constituted the knowing, intentional, or reckless act. We disagree. Driving without insurance is also a Class B infraction. ORS 806.010. Thus, as with careless driving, it is not a crime.

Driving while suspended can be punishable as a crime. See ORS 811.182. Yet, the offense of driving while suspended did not result in the child's injuries. We addressed a similar issue in Dianna Lawton, 38 Van Natta 1543 (1986). In Lawton, the applicant was struck by a vehicle while she was crossing the street by means of a crosswalk. The driver was cited for failing to yield the right of way to a pedestrian and for driving while her license was suspended. We concluded that failing to yield the right of way was a Class B traffic infraction and, thus, not a compensable crime. In addition, we reasoned that although the offense of driving while suspended was a knowing act, the commission of the offense was not the act which resulted in the applicant's injuries. Rather, we found that the act which caused the applicant's injuries was the driver's failure to yield the right of way. Inasmuch as failing to yield the right of way was not "an intentional, knowing or reckless act" that would be "punishable as a crime in this state," we held that the applicant was not the victim of a "compensable crime."

Here, as in Lawton, the driver's decision to drive while his license was suspended was not the offense which contributed to the cause of the injuries sustained by applicant's son. Instead, the offense which contributed to the child's injuries was the driver's careless driving. Since careless driving is not "an intentional, knowing or reckless act" that would be "punishable as a crime in this state," we conclude that applicant was not the victim of a "compensable crime." See ORS 147.005(4); 147.015.

We empathize with the mental anguish and financial burden experienced by applicant and his family as a result of this unfortunate accident. However, the Act provides for benefits to injured victims, subject to very specific requirements. As discussed above, applicant's situation does not meet those statutory requirements. Consequently, the remedy for his damages does not lie with the Crime Victim Compensation Fund.

ORDER

The Findings of Fact, Conclusions and Order on Reconsideration of the Department of Justice Crime Victim Program dated November 24, 1987 is affirmed.

GEORGE F. BASS, Claimant
Michael B. Dye, Claimant's Attorney
SAIF Corp Legal, Defense Attorney

Own Motion 87-0632M
May 10, 1988
Consent to Issuance of Order Designating a Paying Agent (ORS 656.307)

The Compliance Division has notified the Board that it is prepared to issue an order designating a paying agent under ORS 656.307 and OAR 436-60-180. Each of the employers/insurers have acknowledged that the only issue is responsibility for claimant's otherwise compensable claim. Claimant's aggravation rights under his claim with SAIF Corporation has expired. Thus, that claim is subject to ORS 656.278.

Pursuant to OAR 438-12-032(3), the Board shall notify the Compliance Division that it consents to the order designating a paying agent, if it finds that the claimant would be entitled to own motion relief if the own motion insurer is the party responsible for payment of compensation. The Board may exercise its own motion jurisdiction if there is a worsening of a compensable injury that requires either inpatient or outpatient surgery or other treatment requiring hospitalization. ORS 656.278(1)(a). In such cases, the Board may authorize the payment of temporary disability compensation from the time the worker is actually hospitalized or undergoes outpatient surgery until the worker's condition becomes medically stationary, as determined by the Board. id.

The record establishes that there has been a worsening of claimant's compensable injury requiring either inpatient or outpatient surgery or other treatment requiring hospitalization. Inasmuch as claimant would be entitled to own motion relief if the own motion insurer is found responsible for claimant's current condition, the Board consents to the order designating a paying agent. Furthermore, for the purposes of ORS 656.625 and OAR 436, Division 45, this consent constitutes an order reopening a claim under ORS 656.278 and the Board's rules if the designated paying agent is an own motion insurer. See OAR 438-12-032(3).

IT IS SO ORDERED.

JOHN H. BEMENT, Claimant
Quintin B. Estell, Claimant's Attorney
Merrily McCabe (SAIF), Defense Attorney

WCB 87-14570
May 10, 1988
Order on Review

Reviewed by Board Members Ferris and Crider.

Claimant requests review of Presiding Referee Daughtry's order dismissing claimant's request for hearing. The sole issue is dismissal. We affirm.

FINDINGS OF FACT

On September 22, 1987, claimant filed a request for hearing on a Determination Order. The SAIF Corporation filed a response to the request on October 26, 1987. On November 13, 1987, claimant filed a motion to dismiss the hearing request without prejudice. Referee Daughtry entered a dismissal order on

December 3, 1987. The order did not specify whether the dismissal was "with prejudice" or "without prejudice."

CONCLUSIONS AND OPINION

On review, claimant contends that the Referee's dismissal order should be modified to read that it was issued "without prejudice." We decline to do so, because it is our policy to interpret any dismissal order issued by the Hearings Division as an order of "dismissal without prejudice," unless the order states otherwise. Consequently, modification is unnecessary.

ORDER

The Referee's order dated December 3, 1987 is affirmed.

JESSIE ERICKSON, Claimant
Malagon & Moore, Claimant's Attorneys
Bottini, et al., Defense Attorneys

WCB 87-00435
May 10, 1988
Order on Review

Reviewed by Board Members Johnson and Ferris.

The self-insured employer requests review of that portion of Referee Hettle's order that set aside its denial of claimant's current chiropractic treatments for her compensable back condition. On review, the issue is medical services. We affirm.

FINDINGS OF FACT

On April 15, 1982, claimant suffered a compensable back injury when she slipped while walking down a ramp. Five months after the injury, claimant treated with Dr. Shirk, chiropractor. He diagnosed subluxations of C6 and T6, post-traumatic cervical dorsal lumbar strain with muscle spasms, myositis, and extension neuralgia radiating to the trajectory of the left sciatic plexus. Claimant's primary complaint was chronic headaches. Dr. Shirk began conservative treatment. Claimant was not released from work.

On December 13, 1982, Dr. Shirk found claimant medically stationary without permanent impairment. He noted claimant would have periodic symptoms that would require treatment.

In December 1984, claimant was examined by Dr. Habjan, M.D., for right leg discomfort. He recommended aspirin and heat with continued care as needed.

Between October 1986 and October 1987 claimant was examined by three chiropractors.

Claimant did not have back problems or chronic headaches before her April 15, 1982 injury.

Claimant's condition and need for medical treatment is related to her compensable injury suffered in April 1982.

CONCLUSIONS OF LAW AND OPINION

It is claimant's burden to prove that her current condition and need for medical treatment are related to her compensable injury. ORS 656.245; West v. SAIF 74 Or App 317 (1985).

Dr. Shirk, the treating chiropractor, related claimant's

condition to her April 15, 1982 injury. Dr. Peterson, an examining chiropractor, disagreed; he concluded that any symptoms of the original injury should have resolved within a few months.

The employer contends that Dr. Shirk's opinion is not as persuasive as the opinion of Dr. Peterson, and that the Referee erred in relying on Dr. Shirk. We disagree.

Dr. Shirk's opinion is detailed and well-reasoned. He reported that claimant's physical findings consisted of right lumbosacral pain on Kemps and Ely's tests, posterior lower cervical pain on forearm compression tests, extreme tenderness over the lumbosacral and lower cervical spinal soft tissues and motor unit hypermobility of L5-S1 and C6-C7 on motion palpatation. Dr. Shirk indicated that the claimant's x-rays demonstrated mild disc degeneration of C5-C6, C6-C7 and spondylosis of C5 anterior vertebral body. Basing his opinion on claimant's history, physical findings and symptoms, Dr. Shirk concluded that claimant's condition was related to her April 1982 injury.

Dr. Shirk initially treated claimant and has continued to treat her periodically. He found claimant medically stationary in December 1982, with no permanent impairment and noted that she would require ongoing palliative treatment.

In October 1986, Dr. Shirk related claimant's condition to her compensable injury. A treating physician's opinion is relied upon absent persuasive reasons to the contrary. Weiland v. SAIF, 64 Or App 810 (1983). Furthermore, Shirk's opinion is supported by the opinions of Drs. Habjan and Burdell, both of whom found a continuing relationship between claimant's symptoms and the compensable injury.

We find the aforementiond opinions and findings more persuasive than Dr. Peterson's opinion that her symptoms should have been resolved in three to four months.

Having found that the claimant's symptoms are related to the compensable injury, we agree with the Referee that the denial of chiropractic treatment should be set aside.

ORDER

The Referee's order dated December 22, 1987 is affirmed. Claimant's attorney is awarded an assessed fee of $962.50, to be paid by the self-insured employer. The Board approves a client-paid fee not to exceed $1,468.

ELSON MARTIN, Claimant
Velure & Yates, Claimant's Attorneys
SAIF Corp Legal, Defense Attorney

Own Motion 88-0152M
May 10, 1988
Own Motion Order

SAIF Corporation has submitted to the Board claimant's claim for an alleged worsening of his April 6, 1978 industrial injury. Claimant's aggravation rights have expired. SAIF opposes reopening of this claim for temporary total disability compensation as claimant has been out of the work force since at least 1985. Claimant contends he has worked regularly except for those times he was recovering from surgery.

Pursuant to ORS 656.278(1)(a), we may exercise our own motion authority when we find that there is a worsening of a compensable injury that requires either inpatient or outpatient

surgery or other treatment requiring hospitalization. Claimant underwent a ganglionectomy recently, which has been accepted by SAIF Corporation. The only issue to be resolved is whether or not claimant had retired from the work force prior to the surgical procedure and, therefore, may not be awarded temporary disability benefits.

The evidence indicates that claimant was receiving temporary total disability compensation from September 24, 1985 through June 9, 1987. His claim was closed by Board order dated July 28, 1987. In a subsequent order, dated December 21, 1987, claimant was granted an increased award for permanent partial disability. Although there is no evidence that claimant returned to work after his claim was closed, it appears that he did participate in return to work services until December 1987. Surgery was recommended soon thereafter. We conclude claimant has not removed himself from the work force so as to preclude him from temporary total disability compensation during his recovery from surgery.

Claimant's claim is hereby reopened with temporary total disability compensation to commence March 1, 1988, the date of the surgery, and to continue until claimant returns to his regular work at his regular wage or is medically stationary, whichever is earlier. Claimant's attorney is awarded 25% of the additional compensation granted by this order, not to exceed $300 as a reasonable attorney's fee. Reimbursement from the Reopened Claims Reserve is authorized to the extent allowed under ORS 656.625 and OAR 436, Division 45. When appropriate, the claim shall be closed by the insurer pursuant to OAR 438-12-055.

FRANKIE L. McDONALD, Claimant
Gary L. Susak, Claimant's Attorney
Rick Barber (SAIF), Defense Attorney

WCB 87-10673
May 10, 1988
Order on Review

Reviewed by Board Members Johnson and Ferris.

Claimant requests review of Referee Peterson's order that increased her unscheduled permanent disability award for a low back condition from 30 percent (96 degrees), as granted by Determination Order, to 50 percent (160 degrees). On review the issue is permanent total disability. We affirm.

FINDINGS OF FACT

On July 15, 1982, claimant, 64 years of age at the time of hearing, compensably injured her back while lifting a kettle. She began treating with Dr. Hall, chiropractor, who diagnosed an acute back strain and began conservative treatment.

Previously, in 1966, claimant had incurred low back pain after falling at her work place. In 1970, she again developed back pain after a lifting incident and was off work for one week.

Claimant has completed the ninth grade. Her work history includes experience as a waitress, cook and bartender.

In May 1985 Dr. Hall took claimant off work for approximately two weeks. He continued to treat her conservatively with physiotherapy and pain medication.

Between July 1985 and February 1987 claimant was examined by several physicians and chiropractors. On February 20, 1987, claimant entered into a Disputed Claim Settlement with the insurer concerning cervical dorsal problems, bilateral carpal tunnel syndrome and vascular disease.

None of claimant's physicians have stated that she is unable to work.

Claimant is limited to lifting not more than 20 pounds. Walking, standing and sitting are limited and she cannot bend stoop, squat or twist.

Following her compensable injury, claimant made no attempt to find gainful and suitable work.

CONCLUSIONS OF LAW AND OPINION

Claimant contends that she is permanently and totally disabled. She bases her argument on the "futility doctrine."

In order to prove entitlement to compensation for permanent total disability, claimant must prove that she is permanently incapacitated from regularly performing work at a gainful and suitable occupation. Wilson v. Weyerhaeuser Co., 3o Or App 403 (1977). A "suitable occupation" is one which the worker has the ability and training or experience to perform, or one the worker can perform after rehabilitation. ORS 656.206(1). Furthermore, the worker must make reasonable efforts to obtain regular gainful employment. Shaw v. Portland Laundry/Dry Cleaning, 47 Or App 1041 (1980). A claimant need not, however, make efforts to work if those efforts would be futile. Butcher v. SAIF, 45 Or App 313 (1980).

Dr. Martens, orthopedist and Dr. Gancher, neurologist, reported claimant could return to her regular job with limitations of no stooping, bending or lifting over 20 pounds.

Dr. Dinneen, orthopedist, stated that in the physical capacity category claimant could do the duties of the average 64-year-old woman.

Although claimant has limitations and restrictions on her activities, none of her doctors have stated that she is unable to work. Claimant's doctors uniformly indicate that she is capable of light-duty work. The doctors' reports are detailed and well-reasoned. Therefore, we are persuaded that claimant is capable of light-duty work.

Furthermore, there is no evidence in the record that claimant has made reasonable efforts to obtain regular gainful employment. As she is capable of light-duty work, it would not be futile for her to make such efforts. Consequently, claimant is not permanently and totally disabled.

We conclude that the Referee's award of an additional 20 percent permanent disability is adequate compensation for claimant's low back condition.

ORDER

The Referee's order dated December 18, 1987 is affirmed.

ROBERT L. MURPHY, Claimant
Quintin B. Estell, Claimant's Attorney
Rick Dawson (SAIF), Defense Attorney

WCB 86-06489
May 10, 1988
Corrected Order on Review (Remanding)

Reviewed by Board Members Ferris and Crider.

On May 3, 1988, we issued an Order on Review that remanded this case to the Hearings Division. It has come to our attention that our order did not contain a notice of the parties' rights of appeal under such circumstances. To correct this oversight, our prior order is withdrawn and replaced by the following order.

Claimant requests review of Presiding Referee Daughtry's order which dismissed his hearing request. We reverse and direct that the hearing request be reinstated.

FINDINGS OF FACT

On May 9, 1986, claimant requested a hearing on a Determination Order. The issues raised in the request were temporary total disability, permanent partial disability, medical services and premature claim closure. Claimant's claim was subsequently reopened for surgery and, on December 9, 1986, claimant's attorney wrote to the Board, requesting that the case be placed in inactive status until claim closure. The case was placed in inactive status until September 9, 1987. On August 21, 1987, the SAIF Corporation filed its response to the hearing request, denying all contentions raised in the request.

On September 10, 1987, claimant's attorney wrote Presiding Referee Daughtry, requesting that the case remain in inactive status pending claim closure. The case was again placed in inactive status until December 14, 1987.

On November 30, 1987, claimant's attorney wrote Referee Daughtry, requesting that the hearing request be dismissed "with the right to preserve all issues until this claim has been closed and is ready to proceed to hearing." Claimant's attorney also requested that SAIF's attorney prepare a stipulation if there was no objection to the request for dismissal. SAIF's attorney raised no objection to the dismissal request, but prepared no stipulation. On December 14, 1987, Referee Daughtry entered an order of dismissal, noting that the hearing request had been withdrawn. The order did not specify whether the dismissal was "with prejudice" or "without prejudice."

CONCLUSIONS AND OPINION

On review, claimant contends that the Referee's dismissal order should be modified to read that it was issued "without prejudice." We decline to do so for two reasons. First, it is our policy to interpret any dismissal order issued by the Hearings Division as an order of "dismissal without prejudice," unless the order states otherwise. Consequently, modification is unnecessary.

In any event, the requested modification would have little effect on claimant's hearing rights because the one-year limitations period for filing a request for hearing on the

Determination Order has passed. See former ORS 656.319(4). Thus, although the modification would ensure that the dismissal order itself does not preclude another request for hearing on the Determination Order any such hearing request would be precluded by the statute of limitations. If we dismiss without prejudice, claimant will be unable to contest the Determination Order award of temporary total disability compensation. Moreover, although claimant could litigate the issue of permanent partial disability after the issuance of a new Determination Order, he would have the burden of proving that he has become more disabled since the first Determination Order because the first Determination Order will be final and the law of the case. See Stepp v. SAIF, 78 Or App 438, 441-42 (1986).

We do not interpret claimant's November 30, 1987 letter to the Referee as a request for an order of "dismissal without prejudice." Rather, claimant sought to have his case taken off the docket while preserving his right to litigate the issues arising from the first Determination Order. Claimant's hearing rights would have been preserved if his case had remained in inactive status. As a matter of Board policy, a request for hearing on a Determination Order should not be dismissed when the issue of permanent partial disability cannot be litigated because claimant is no longer medically stationary.

Accordingly, we reverse the Referee's order of dismissal and reinstate claimant's hearing request. If the claim is no longer open, the case may be scheduled for hearing. If the claim remains open, the hearing may be deferred under the Board rules.

ORDER

The Referee's dismissal order dated December 14, 1987 is reversed. Claimant's hearing request dated May 9, 1986 is reinstated. This case is remanded to the Hearings Division for further action consistent with this order.

JOHN B. O'RILEY, Claimant
Doblie & Associates, Claimant's Attorneys
Meyers & Terrall, Defense Attorney
Francesconi & Associates, Attorneys

WCB 86-01486
May 10, 1988
Order of Dismissal

Claimant has requested review of Referee Leahy's order dated March 18, 1988. We have reviewed the request to determine whether we have jurisdiction to consider the matter. We conclude that we lack jurisdiction.

FINDINGS

Claimant's request for review of the Referee's March 18, 1988 order was hand-delivered to the Board on April 29, 1988. The request did not include an acknowledgment of service or a certificate of personal service by mail upon the self-insured employer, its claims administrator, or its attorney.

The request for Board review was filed more than 30 days after the date of the Referee's order. Furthermore, neither the employer nor its representatives received notice of claimant's request for review within 30 days after the Referee's order.

CONCLUSIONS

A Referee's order is final unless, within 30 days after

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

Here, the 30th day after the Referee's March 18, 1988 order was April 17, 1988, a Sunday. Thus, the last day to timely file a request for Board review of the Referee's order was Monday, April 18, 1988. See ORS 174.120. Claimant's request for Board review was filed April 29, 1988, some 42 days after the date of the Referee's order. Furthermore, neither the employer nor its representatives were 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 v. King, supra.

We are mindful that claimant has requested review without benefit of legal representation. We further realize that an unrepresented party is not expected to be familiar with administrative and procedural requirements of the Workers' Compensation Law. Yet, we are not free to relax a jurisdictional requirement, particularly in view of Argonaut Insurance Co. v. King, supra. See Alfred F. Puglisi, 39 Van Natta 310 (1987); Julio P. Lopez, 38 Van Natta 862 (1986).

Accordingly, the request for Board review is dismissed.

IT IS SO ORDERED.

WILLIAM H. WILSON, Claimant
Coons & Cole, Claimant's Attorneys
Davis, et al., Defense Attorneys
Lester R. Huntsinger (SAIF), Defense Attorney

Own Motion 87-0068M
May 10, 1988
Order on Motion to Join

By order dated December 31, 1987 the Board referred the above entitled matter to the Hearings Division for an evidentiary hearing regarding claimant's entitlement to permanent total disability compensation. EBI Companies has requested that the Board join SAIF Corporation to the hearing. SAIF opposes claimant's request.

After careful consideration to EBI's motion, the Board denies the request to join SAIF to the proceedings in the Hearings Division. SAIF's 1971 claim (Claim No. C292172) is an own motion claim which is currently in a closed status. As such, we would have no jurisdiction over the issue of permanent disability under the new own motion law. ORS 656.278(1)(a) and OAR 438-12-052(2). The EBI claim, however, has remained in an open status to allow further consideration of permanent disability under the prior own motion law. We conclude that we retain jurisdiction over the permanent disability issue in the EBI claim.

EBI's motion to join SAIF to the hearing currently pending in the Hearings Division is denied.

IT IS SO ORDERED.

SHARON K. SALZER, Claimant
Francesconi & Associates, Claimant's Attorneys
Rankin, et al., Defense Attorneys

WCB 85-12483
May 11, 1988
Second Amended Order on Reconsideration

The self-insured employer requests reconsideration of our April 11, 1988 Order on Reconsideration, as amended April 25, 1988. In accordance with the Court of Appeals' remand order, we reconsidered this case in light of new medical evidence contained in WCB Case No. 87-06505. After conducting our reconsideration, we concluded that claimant's proposed surgery was reasonable and necessary medical treatment resulting from claimant's compensable injury. Consequently, we affirmed the Referee's order that had set aside the employer's denial of the proposed surgery.

The employer moves for reconsideration and clarification of our order, asking that we specify exactly when the proposed surgery became reasonable and necessary. The employer submits that such information is germane to claimant's request for claim reopening under the Board's Own Motion relief in WCB Case No. 87-0438M, a case which is presently pending.

The employer's motion is denied. Pursuant to the court's order, the scope of our remand was expressly limited to the consideration of the reasonableness and necessity of the denied surgery. Claimant's request for claim reopening and time loss was specifically excluded from our consideration. Inasmuch as the employer's request pertains to an issue that is outside the scope of our remand, we are without authority to grant the motion. Moreover, since the issue posed by the employer's request pertains to matters which are subject to the Board's Own Motion relief, we conclude that the employer's argument should be directed to claimant's request for claim reopening in WCB Case No. 87-0438M.

Finally, the employer's counsel has advised us that the $1,246 client-paid fee previously authorized by our April 25, 1988 Amended Order on Reconsideration actually pertained to legal services that were primarily rendered in WCB Case No. 87-06505, a case which was consolidated with this case for purposes of review. This date, in WCB Case No. 87-06505, we have approved a client-paid fee for services rendered in these consolidated cases, not to exceed $1,629.50. The aforementioned authorization is in lieu of, rather than in addition to, the client-paid fee previously approved by our April 25, 1988 order in this case. In other words, the employer's counsel is authorized to charge for services in these consolidated cases a client-paid fee not to exceed $1,629.50.

Accordingly, our April 11, 1988 and April 25, 1988 orders are abated and withdrawn. As amended and supplemented herein, we adhere to and republish our April 11, 1988 order, except that the parties' rights of appeal shall run from the date of this order.

IT IS SO ORDERED.

SHARON K. SALZER, Claimant
Francesconi & Associates, Claimant's Attorneys
Rankin, et al., Defense Attorneys

WCB 87-06505
May 11, 1988
Order on Reconsideration

The self-insured employer has moved for reconsideration and clarification of our April 11, 1988 Order on Review. This case was reviewed in consolidation with WCB Case No. 85-12483, pursuant to the Court of Appeals' March 11, 1988 remand order in that case. After conducting our review, we found claimant's proposed surgery to be compensable. Consequently, we reversed the Referee's order upholding the employer's denial of surgery.

The employer requests reconsideration and clarification of our order. Specifically, the employer asks that we designate the exact date when claimant's proposed surgery became reasonable and necessary. The employer submits that such information is germane to claimant's request for claim reopening under the Board's Own Motion relief in WCB Case No. 87-0438M, a case which is currently pending.

We have denied a similar request made by the employer in WCB Case No. 85-12483. In addition to the reasoning expressed in that case, we conclude that a finding such as that requested by the employer is not relevant to the issue raised by the Referee's order, i.e., whether the proposed surgery is reasonable and necessary medical treatment resulting from claimant's compensable injury. Rather, the issues of whether the claim should be reopened and, if so, when, are solely subject to the Board's Own Motion jurisdiction. As stated in our Second Order on Reconsideration in WCB Case No. 85-12483, the issue raised by the employer's motion for clarification should be directed to WCB Case No. 87-0438M. Consequently, the employer's motion is denied.

The employer's counsel also seeks Board authorization of a client-paid fee for services rendered in these consolidated cases. We have previously approved a client-paid fee in WCB Case No. 85-12483 totalling $1,246. The employer's counsel states that the services for which that fee were approved primarily involved this case.

After review of the statements of services and the attorney retainer agreement, and considering the factors set forth in OAR 438-15-010(6), we approve a client-paid fee for services rendered in these consolidated cases, not to exceed $1,629.50. In other words, this authorization is in lieu of, rather than in addition to, the client-paid fee previously authorized in WCB Case No. 85-12483.

Accordingly, our April 11, 1988 Order on Review is abated and withdrawn. As amended and supplemented herein, we adhere to and republish our April 11, 1988 order, except that the parties' rights of appeal shall run from the date of this order.

IT IS SO ORDERED.

ALICE M. GENTRY, Claimant
Ackerman, et al., Claimant's Attorneys
SAIF Corp Legal, Defense Attorney

Own Motion 88-0195M
May 12, 1988
Own Motion Order

SAIF Corporation has submitted to the Board claimant's claim for an alleged worsening of her July 14, 1976 industrial injury. Claimant's aggravation rights have expired. SAIF Corporation has authorized the recommended surgery, but opposes reopening of this claim for the payment of temporary total disability as it contends claimant has removed herself from the work force.

Pursuant to ORS 656.278(1)(a), we may exercise our "Own Motion" authority when we find that there is a worsening of a compensable injury that requires either inpatient or outpatient surgery or other treatment requiring hospitalization. In such cases, we are authorized to award temporary disability compensation commencing from the time the worker is actually hospitalized or undergoes outpatient surgery.

Surgery has been recommended and authorized by SAIF. The only issue remaining is whether or not claimant is entitled to compensation for temporary total disability during her recovery from surgery. The record before us indicates that although claimant is receiving Social Security Disability benefits, she is also working part time as a babysitter and housekeeper. We are persuaded that claimant has not removed herself from the work force and, therefore, is entitled to compensation for temporary total disability. Claimant's claim is reopened with compensation for temporary total disability to commence the date of the surgery and to continue until claimant returns to her regular work at her regular wage or is medically stationary, whichever is earlier. Claimant's attorney is awarded 25% of the additional compensation granted by this order, not to exceed $250 as a reasonable attorney's fee. Reimbursement from the Reopened Claims Reserve is authorized to the extent allowed under ORS 656.625 and OAR 436, Division 45. When appropriate, the claim shall be closed by the insurer pursuant to OAR 438-12-055.

IT IS SO ORDERED.

RAMONA K. HALFMOON, Claimant
Kenneth Peterson, Claimant's Attorney
Schwabe, et al., Defense Attorneys

WCB 87-12383
May 12, 1988
Order on Review

Reviewed by Board Members Crider and Ferris.

Claimant requests review of Referee Wasley's order that upheld the self-insured employer's denial of her occupational disease claim for bilateral carpal tunnel syndrome. We affirm.

ISSUE

Whether claimant's work activity was the major contributing cause of her bilateral carpal tunnel syndrome.

FINDINGS OF FACT

Claimant worked full time as a potato trimmer from July 21 to August 20, 1986 and from February 3 to June 10, 1987. In this position, claimant picked defective potatoes off a conveyor belt and removed the defects with a knife. She picked up

potatoes with her left hand using a wide spherical grasp and manipulated them during trimming with finger and short arc wrist movements. She held the knife in her right hand using a fixed small diameter grasp and manipulated it with short arc wrist movements.

In late May or early June 1987, claimant began to experience gradually increasing pain in her left wrist and thumb. She also experienced lesser symptoms in her right wrist and the middle and ring fingers of her right hand. She sought treatment on June 10, 1987 from James Smith, a family nurse practitioner. He diagnosed tendonitis of the left wrist, prescribed a left wrist splint and issued a release for work with a restriction of no use of the left hand. Claimant filed a claim for her wrists and hands on June 10, 1987. She had experienced numbness of unknown etiology in her right middle finger since a neck injury sustained in an automobile accident in 1985.

Claimant returned to work on June 24, 1987 on the french fry line. (See Ex. 2A-3, 2A-4; Tr. 44-45). Two days before returning to work, claimant complained to Mr. Smith of continuing pain in her left wrist and increasing numbness in her right wrist and the second, third and fourth fingers of her right hand. (Ex. 2A-2). On the french fry line, claimant picked defective french fries off a conveyor belt by pinching them between the thumb and index finger of her right hand and discarding them with mid range flexion and extension movements of the wrist. Claimant returned to Mr. Smith on July 6, 1987 with complaints of continuing pain and numbness in both wrists and hands.

Claimant was examined by Dr. Nathan, a hand specialist, on July 20, 1987. He ordered nerve conduction studies which revealed impingement of both median nerves at the wrists, worse on the right. He diagnosed bilateral carpal tunnel syndrome, idiopathic, and recommended surgical releases of the carpal tunnels. The employer denied the compensability of claimant's claim on August 3, 1987. Carpal tunnel releases were performed by Dr. Carpenter, an orthopedist, in September 1987. These surgeries greatly reduced claimant's symptoms. Claimant remained off work from July 6, 1987 until after her surgeries. Her wrist and hand symptoms continued at the same level during this entire period.

Carpal tunnel syndrome is a symptom complex affecting the wrist and hand and is caused by compression of the median nerve in the carpal tunnel. This compression results from changes in the tissues within the carpal tunnel associated with one or more of the following: thyroid disease, diabetes, rheumatoid arthritis, pregnancy, tumors, acute trauma to the wrist (including fractures), repetitive full flexion and extension of the wrist (see Tr. 4-5) and other unknown causes. Carpal tunnel syndromes associated with repetitive flexion and extension of the wrist will normally abate and resolve with the cessation of such activity. If repetitive flexion and extension of the wrist is continued more than six months after the appearance of symptoms, however, the condition will usually become irreversible and require surgical treatment.

Claimant has no history of thyroid disease, diabetes, rheumatoid arthritis or acute trauma to her wrists. Some of the numbness in claimant's right hand may be associated with her 1985 neck injury. The nerve conduction studies ordered by Dr. Nathan, however, also confirmed median nerve compression at the right

wrist. Claimant was not pregnant at any time relevant to this case and no tumors were found during surgery. The wrist movements associated with claimant's jobs as a potato trimmer and french fry picker are not those usually associated with the onset or worsening of carpal tunnel syndrome. (See Ex. 5). In addition to her work activities, claimant performed unspecified household chores which may have involved repetitive flexion and extension of her wrists. (See Tr. 39).

OPINION AND CONCLUSIONS

To establish a compensable occupational disease, claimant has the burden of proving that her work activities were the major contributing cause of either the onset or worsening of her disease. See former ORS 656.802(1)(a); Dethlefs v. Hyster Co., 295 Or 298, 310 (1983); Blakely v. SAIF, 89 Or App 653, 656 (1988). "Major contributing cause" means a cause or combination of causes which contributes more to the onset or worsening than all other causes combined. See McGarrah v. SAIF, 296 Or 145, 166 (1983); Dethlefs v. Hyster Co., supra, 295 Or at 309-10; Clark v. Erdman Meat Packing, 88 Or App 1, 5 (1987). Claimant's disease was the change in the tissues within her carpal tunnels which resulted in the compression of her median nerves. She contends that the wrist and hand movements associated with her employment were the major contributing cause of these tissue changes. We conclude that the record fails to support this contention.

First, the wrist and hand movements associated with claimant's employment were not of a type normally associated with the onset or worsening of carpal tunnel syndrome. Second, even assuming that they were, the evidence indicates that these movements were not the major contributing cause of the onset or worsening of the tissue changes. Claimant first noticed symptoms of carpal tunnel syndrome in connection with her work activity. That fact tends to suggest that the condition was caused by work activity. Claimant left work within a few weeks, however, and her symptoms continued and even increased. These facts are inconsistent with the normal course of a carpal tunnel syndrome caused by repetitive flexion and extension of the wrist and strongly support the inference that the major if not sole cause of the condition was either some off-work activity or some unknown or unrecognized bodily process peculiar to claimant.

Third, Dr. Nathan, a specialist in disorders of the hand, opined on the basis of a complete and accurate history that claimant's condition was not work related. Dr. Carpenter, the only physician who offered an opinion which tends to favor a finding of compensability, was able to say only that there was a "possibility" that claimant's work activity was "a major contributing cause" of her condition. (Emphasis added). Although "magic words" are not necessary to a finding of compensability, their absence certainly does not strengthen claimant's case. This is especially true in light of the rest of Dr. Carpenter's testimony which was characterized by generalizations and qualifications. In addition, when Dr. Carpenter was questioned concerning why claimant's symptoms did not diminish after she left work, he was unable to offer an explanation.

For all of the above reasons, we conclude that claimant has failed to establish by a preponderance of the evidence that her work activity was the major contributing cause of either the

onset or worsening of her carpal tunnel syndromes. The employer's denial, therefore, shall be upheld.

ORDER

The Referee's order dated December 29, 1987 is affirmed. Counsel for the self-insured employer is authorized to charge a client-paid fee of up to $1,104 for services on Board review.

STEVEN B. LUBITZ, Claimant
Vick & Gutzler, Claimant's Attorneys
Rankin, et al., Defense Attorneys

WCB TP-88005
May 12, 1988
Third Party Order

The self-insured employer, as paying agency, has petitioned the Board to resolve a dispute concerning the proper distribution of the proceeds of a third party settlement. See ORS 656.593(3). Specifically, the employer asserts that claimant failed to distribute the proceeds in accordance with ORS 656.593(1), as previously directed by our September 24, 1987 Third Party Order. We agree.

FINDINGS

In August 1984 claimant sustained a compensable neck and low back injury. He initiated a cause of action against a third party. Claimant and the third party agreed to settle the cause of action for $10,000. The paying agency opposed the settlement, contending that full satisfaction of its current $19,794.68 lien was possible.

Claimant petitioned the Board to resolve the dispute over the settlement. On September 24, 1987, we approved the settlement. We further directed that the proceeds of the $10,000 settlement be distributed in accordance with ORS 656.593(1).

Claimant's attorney did not distribute the proceeds in accordance with ORS 656.593(1). Rather, after deducting claimant's 1/3 attorney's fee ($3,333.33) and litigation costs ($231.94), claimant's attorney disbursed $3,702.50 to claimant's treating physician. From the remaining balance of $2,732.23, claimant's attorney distributed 25 percent ($683.05) to claimant and the remaining $2,049.18 to the paying agency. Claimant's counsel then reduced her fee to $2,000, enabling claimant to recover an additional $1,333.33.

The money distributed to claimant's treating physician satisfied claimant's outstanding balance for chiropractic treatments. These treatments had been the subject of two prior denials issued by the paying agency. The compensability of these treatments had been resolved pursuant to an August 1986 Stipulation. Under the stipulation, the agency's denials were "affirmed in their entirety." The parties further expressed their position that claimant was not liable for the outstanding medical costs and that the denials precluded recovery of the medical charges from the agency. However, in the event that the medical providers sought repayment from the agency, claimant agreed to "hold [the agency] harmless from responsibility therefor."

Pursuant to ORS 656.593(1), the proceeds of the third party settlement should have been distributed as follows. After

deducting for claimant's attorney's fee ($3,333.33) and litigation costs ($231.94), claimant should have received 1/3 of the $6,438.06 remaining balance. ($2,146.02). The remainder of the proceeds, $4,292.04, should have been distributed to the paying agency.

CONTENTIONS

Instead of receiving $4,292.04, as it should have under the statutory distribution scheme of ORS 656.593(1), the paying agency asserts that it has received only $2,049.18. It contends that claimant's attorney's disbursement of a portion of the settlement's proceeds to claimant's treating chiropractor is contrary to the provisions of ORS 656.593(1). Since this misguided disbursement was caused by claimant's attorney's unauthorized action, the agency submits that claimant's attorney should be directed to pay the remaining balance of the agency's statutory share of the settlement, i.e, $2,242.86.

Claimant's counsel responds that the outstanding medical bill represents expenses incurred by claimant as a result of the third party's actions. Since the third party claim was settled, it is claimant's attorney's position that a medical provider is entitled to the "amount he [would have] testified to." Claimant's counsel further submits that claimant agreed to settle the claim with the understanding that his physician's bill would be paid. Should we conclude that the distribution was improper, claimant's attorney is prepared to assist the agency in recovering the money from the physician.

CONCLUSIONS

If a worker receives a compensable injury due to the negligence or wrong of a third person not in the same employ, the worker shall elect whether to recover damages from such third person. ORS 656.578. The proceeds of any damages recovered from a third person by the worker shall be subject to a lien of the paying agency for its share of the proceeds. ORS 656.593. The paying agency's lien shall be preferred to all claims except the cost of recovering damages from the third party. ORS 656.580(2).

The statutory scheme for the allocation of damages is precise. Robert B. Williams, 38 Van Natta 119, 123 (1986), aff'd. Estate of Troy Vance v. Williams, 84 Or App 616 (1987). ORS 656.593(1) provides in detail exactly how, and in what order, the damages shall be distributed.

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

Here, the Board resolved the parties' dispute concerning the proposed third party settlement. Pursuant to the Board's

September 24, 1987 Third Party Order, the settlement offer of $10,000 was approved. In conjunction with its approval, the Board further directed that the proceeds of the settlement be distributed in accordance with ORS 656.593(1).

ORS 656.593(1) sets forth a distribution scheme, which includes three specific entities. These entities are claimant's attorney, claimant, and the paying agency. The statute does not provide for the disbursement of any portion of the proceeds from a third party recovery directly to a physician, medical services provider, or any other entity.

In accordance with ORS 656.593(1), the proceeds of the $10,000 third party settlement should have been distributed as follows:

Attorney Fees / Costs:	$3,561.94
1/3 Share to Claimant:	$2,146.02
Paying Agency:	$4,292.04

Despite the Board's specific directions concerning the disbursement of proceeds and the express language of ORS 656.593(1), claimant's attorney proceeded to distribute a portion of the settlement to claimant's treating physician. Regardless of claimant's and his counsel's intentions, such a disbursement was clearly contrary to ORS 656.593(1) and, thereby, the Board's order.

As a result of this unauthorized action, the paying agency has received only $2,049.18 of the $4,292.04 to which it is statutorily entitled. Since this unfortunate situation was prompted by claimant's attorney's invalid distribution of the settlement's proceeds, we conclude that it is claimant's attorney's responsibility to remedy the matter.

Accordingly, claimant's attorney is directed to pay the agency the remaining balance of its statutory share of the proceeds. ie, $2,242.86.

IT IS SO ORDERED.

AGATHA MORSS, Claimant
SAIF Corp Legal, Defense Attorney

Own Motion 88-0189M
May 12, 1988
Own Motion Order

SAIF Corporation has submitted to the Board claimant's claim for an alleged worsening of her March 16, 1977 industrial injury. Claimant's aggravation rights have expired. SAIF opposes reopening as claimant's treatment, to date, has been diagnostic and no surgery has been recommended.

Pursuant to ORS 656.278(1)(a), we may exercise our "Own Motion" authority when we find that there is a worsening of a compensable injury that requires either inpatient or outpatient surgery or other treatment requiring hospitalization. In such cases, we are authorized to award temporary disability compensation commencing from the time the worker is actually hospitalized or undergoes outpatient surgery. Although there is some mention of a possible fusion, there is no evidence before us to indicate that claimant's doctor has requested authorization for any surgical procedure. We conclude that the treatment offered claimant thus far fails to meet the requirements stated above and,

therefore, the Board has no authority to consider claim reopening. The request for own motion relief is hereby denied.

IT IS SO ORDERED.

CLARENCE W. ODAM, Claimant
Haugh & Foote, Claimant's Attorneys
SAIF Corp Legal, Defense Attorney

WCB 87-08441
May 12, 1988
Order on Review

Reviewed by Board Members Ferris and Crider.

Claimant requests review of Referee Thye's order which: (1) awarded 12.5 percent (40 degrees) unscheduled permanent disability for a low back injury, whereas a Determination Order had awarded no unscheduled disability; and (2) affirmed a Determination Order award of 45 percent (67.5 degrees) scheduled permanent disability for the loss of use or function of the left leg (hip). The sole issue is extent of permanent disability, scheduled and unscheduled.

We affirm the Referee's scheduled disability award, but modify the unscheduled disability award.

FINDINGS OF FACT

Claimant compensably injured his low back and right hip on January 28, 1985, while employed as a part-time furnace repairman. The initial diagnosis was an acute traumatic right lumbosacral and gluteal strain. Claimant returned to regular work and began treating conservatively with Dr. Fladoos, a chiropractor.

During the following year, claimant experienced periodic, severe exacerbations of his low back condition whenever he attempted to lift while in a kneeling or crouching position. In January 1986, Dr. Fladoos restricted claimant to modified work and recommended retraining for less strenuous work activity.

In October 1986, claimant was referred to Dr. Franks, a neurosurgeon. When x-rays and a CT scan revealed no nerve root compression, Franks referred claimant to Dr. Neufeld, an orthopedist. In November 1986, Neufeld reported "significant guarding" of the right hip due to probable synovitis and prescribed anti-inflammatory medication. The medication yielded no significant improvement. Claimant became medically stationary on December 23, 1986.

Vocational assistance began in May 1986. An employment goal in church maintenance was developed; however, claimant's eligibility for vocational assistance expired in October 1987 before such work could be found.

The claim was closed by Determination Order on April 16, 1987 with 45 percent scheduled permanent disability for the loss of use or function of the left leg (hip).

Claimant has sustained a permanent loss of right hip motion; the hip joint is capable of no rotation, abduction to 10 degrees, and flexion to 80 degrees. Claimant also has minimal permanent impairment in his low back.

At the time of hearing, claimant continued to experience

pain in the right hip and low back during strenuous activity. Prolonged walking, standing, bending and squatting cause fatigue and pain in his right hip and leg. He has difficulties maintaining his balance while walking and his right hip had "given way" on two occasions. He sometimes experiences pain and discomfort while sitting. He continues to treat with Dr. Fladoos once or twice per week.

Claimant, who was 72 years of age at the time of hearing, has a ninth grade education. His prior work experience includes furnace and oil burner installation and repair, supervision of school cabinet/maintenance shop, dry-cleaning equipment maintenance, ship-fitting, and shoe manufacturing. Claimant attempted to return to work in furnace repair and carpentry following his injury, but was unsuccessful due to back and hip pain. He can perform light work only, which involves lifting up to 20 pounds maximum.

CONCLUSIONS AND OPINION

The Referee awarded claimant 12.5 percent unscheduled permanent disability for his low back injury, and found that claimant was adequately compensated by the Determination Order award of 45 percent scheduled permanent disability for the loss of use or function of the left leg (hip). We agree with the Referee's scheduled disability award; however, we do not agree that the Referee's unscheduled disability award adequately compensates claimant for his low back injury.

The criterion for rating unscheduled permanent disability is the permanent loss of earning capacity due to the compensable injury. ORS 656.214(5). In determining the loss of earning capacity, we consider medical and lay evidence of physical impairment resulting from the compensable injury and all of the relevant social and vocational factors set forth in OAR 436-30-380 et seq. We apply these rules as guidelines, not as restrictive mechanical formulas. Harwell v. Argonaut Insurance Co., 296 Or 505, 510 (1984); Fraijo v. Fred N. Bay News Co., 59 Or App 260, 269 (1982).

Only Drs. Neufeld and Fladoos evaluated claimant's low back impairment after he had achieved medically stationary status. Dr. Neufeld reported in March 1987 that claimant's back problems were not significant and that "most of the impairment is from the hip area," thereby implying that at least some degree of claimant's physical impairment was due to the low back condition. In September 1987, Dr. Fladoos, the treating chiropractor, wrote that simple household tasks continue to irritate claimant's low back. The medical evidence of permanent low back impairment was further bolstered by claimant's testimony that he continues to experience pain and discomfort in the low back during strenuous activity. After our review of the medical and lay evidence, we find that claimant sustained minimal low back impairment.

Claimant's advanced age, limited education, work experience, adaptability to less strenuous physical labor, and unpromising labor market potential further impact his earning capacity. After considering these aforementioned factors, we conclude that a 35 percent (112 degrees) unscheduled permanent disability award adequately compensates claimant for his low back injury.

The criterion for rating scheduled permanent disability is the permanent loss of use or function of the injured member due to the compensable injury. ORS 656.214(2). OAR 436-30-330 and 436-30-340 set forth guidelines to assist in the determination of the extent of permanent disability caused by a leg (hip) injury. These rules are not binding, see Harwell, supra; however, they are highly persuasive because they are based on accepted medical principles.

Dr. Neufeld, an orthopedist who examined claimant in November and December 1986, evaluated claimant's range of right hip motion and found no rotation, abduction to 10 degrees, and flexion to 80 degrees. Physicians at the Western Medical Consultants reached slightly different findings in their evaluations of claimant's range of hip motion in March and August 1986. Because Neufeld performed his evaluation in close temporal proximity to claimant's medically stationary date of December 23, 1986, his findings more closely reflect claimant's permanent loss of hip motion due to the compensable injury. We were therefore most persuaded by Neufeld's findings.

In addition to the loss of hip motion, claimant's use and function of the right leg (hip) are permanently impaired by other symptoms, including disabling pain, fatigue and hip joint instability. After considering the aforementioned guidelines, we conclude that claimant was adequately compensated by 45 percent scheduled disability for the permanent loss of use or function of the right leg (hip).

ORDER

The Referee's order dated December 29, 1987 is modified in part and affirmed in part. That portion of the order which awarded claimant 12.5 percent (40 degrees) unscheduled permanent disability is modified. In addition to the Referee's award, claimant is awarded 22.5 percent (72 degrees) unscheduled permanent disability, giving him a total unscheduled award of 35 percent (112 degrees). Claimant's attorney shall receive 25 percent of the increased compensation granted by this order. The remainder of the Referee's order is affirmed.

DANNY L. BABBITT, Claimant
Connolly & Bruce, Claimant's Attorneys
EBI, Defense Attorney

Own Motion 88-0187M
May 13, 1988
Own Motion Order

The insurer has submitted to the Board claimant's claim for an alleged worsening of his October 17, 1980 industrial injury. Claimant's aggravation rights have expired. The insurer opposes reopening of this claim as there has been no hospitalization for treatment or surgery recommended at this time.

Although the insurer is currently paying claimant's medical expenses, it continues to investigate the possibility of a new injury. We conclude it would be appropriate to review this matter, whether or not EBI is determined ultimately to be responsible for claimant's current condition. Pursuant to ORS 656.278(1)(a), we may exercise our own motion authority when we find that there is a worsening of a compensable injury that requires either inpatient or outpatient surgery or other treatment requiring hospitalization. None of the above treatment modalities have been recommended in this case. We conclude we have no

authority to grant the relief claimant seeks and deny the request for own motion relief.

IT IS SO ORDERED.

KEITH WILKEN, Claimant
Martin J. McKeown, Claimant's Attorney
SAIF Corp Legal, Defense Attorney

Own Motion 87-0417M
May 13, 1988
Own Motion Order

Claimant has requested that the Board exercise its own motion authority and reopen his claim for an alleged worsening of his March 7, 1980 industrial injury. Claimant's aggravation rights have expired. SAIF Corporation has never advised the Board of its position with respect to claimant's request.

Pursuant to ORS 656.278(1)(a), we may exercise our "Own Motion" authority when we find that there is a worsening of a compensable injury that requires either inpatient or outpatient surgery or other treatment requiring hospitalization. In such cases, we are authorized to award temporary disability compensation commencing from the time the worker is actually hospitalized or undergoes outpatient surgery. The medical evidence before us indicates that claimant needs a job change in order to minimize his exposure to noxious fumes. There is no indication in our record that claimant has been hospitalized for treatment or has undergone surgery. We are, therefore, without authority to grant the relief claimant seeks. The request for own motion relief is hereby denied.

IT IS SO ORDERED.

LEWIS THURSTON, Claimant
Michael B. Dye, Claimant's Attorney
SAIF Corp Legal, Defense Attorney

Own Motion 87-0686M
May 13, 1988
Own Motion Order on Reconsideration

The Board issued an Own Motion Order on December 11, 1987 whereby claimant's request for own motion relief was denied as it was found that he had been out of the work force since November 1986. Claimant has submitted additional evidence to show that he continued to look for employment through at least July 1987, just shortly prior to the worsening of his condition. Claimant asks the Board to reconsider its earlier decision based on this new evidence.

The Board has given careful consideration to claimant's new evidence and concludes that he has shown he continued to look for work and was available for work shortly before his condition worsened. We conclude that Cutright v. Weyerhaeuser Company, 299 Or 290 (1985), does not preclude him from benefits due under ORS 656.278.

Claimant's claim is currently in a closed status and, as such, must be considered under the new own motion law, which took effect January 1, 1988. Pursuant to ORS 656.278(1)(a), we may exercise our own motion authority when we find that there is a worsening of a compensable injury that requires either inpatient or outpatient surgery or other treatment requiring hospitalization. In such cases, we are authorized to award temporary disability compensation commencing from the time the worker is actually hospitalized or undergoes outpatient surgery. Accordingly, claimant's claim is reopened with temporary total

disability compensation to commence December 17, 1987, the date of his surgery, and to continue until claimant returns to his regular work at his regular wage or is medically stationary, whichever is earlier. Claimant's attorney is awarded 25% of the additional compensation granted by this order, not to exceed $400 as a reasonable attorney's fee. Reimbursement from the Reopened Claims Reserve is authorized to the extent allowed under ORS 656.625 and OAR 436, Division 45. When appropriate, the claim shall be closed by the insurer pursuant to OAR 438-12-055.

IT IS SO ORDERED.

WILLIAM W. McGHEE, Claimant
Argonaut Insurance Co., Carrier

Own Motion 87-0079M
May 13, 1988
Own Motion Order

The Board issued an Own Motion Order on March 17, 1987 whereby claimant's claim was reopened. Although the claim has not yet been closed, temporary total disability compensation was limited by that order to include the dates December 26, 1986 through January 11, 1987 only. Claimant was hospitalized on January 2, 1988 for gastrointestinal problems due to the use of Feldene which had been prescribed for his compensable right knee condition. The insurer has submitted the claim to the Board for consideration under ORS 656.278. It recommends that the Board authorize temporary total disability compensation from January 2, 1988.

Claimant's claim remains in a open status and, as such, shall continue to be processed under the own motion rules in effect at the time of reopening in March 1987. We conclude claimant is entitled to compensation for temporary total disability commencing January 2, 1988 and continuing, less time worked, until closure pursuant to ORS 656.278.

IT IS SO ORDERED.

BRIAN ROGERS, Claimant
Coons & Cole, Claimant's Attorneys
SAIF Corp, Carrier

Own Motion 87-0010M
May 13, 1988
Own Motion Determination on Reconsideration

The Board issued an Own Motion Determination on May 29, 1987 whereby claimant's claim was closed with no additional award for permanent partial disability. On October 2, 1987, a second order issued specifically denying claimant's request for further permanent partial disability. Claimant again asks the Board to grant him an award for his permanent disability.

The Board carefully considered claimant's entitlement to permanent disability compensation at the time the October 2, 1987 order was issued. Nothing new has been submitted to change the findings in that order. We also note that, as claimant's claim is in a closed status, all requests for compensation must be considered under the current own motion law which took effect on January 1, 1988. Pursuant to the new law, we are without authority to increase permanent disability awards in claims which have gone beyond the five-year aggravation period. ORS 656.278(1)(a). Claimant's request for further relief must be denied.

IT IS SO ORDERED.

JAMES M. BROWN, Claimant
SAIF, Insurance Carrier

Own Motion 88-0173M
May 18, 1988
Own Motion Order

SAIF Corporation has submitted to the Board claimant's claim for an alleged worsening of his March 9, 1980 industrial injury. Claimant's aggravation rights have expired. SAIF opposes reopening of this claim for the payment of temporary total disability as claimant's treatment was diagnostic only.

Claimant lost four days from work commencing March 15. Two of those days were spent in the hospital for diagnostic testing. Pursuant to ORS 656.278(1)(a), we may exercise our "Own Motion" authority when we find that there is a worsening of a compensable injury that requires either inpatient or outpatient surgery or other treatment requiring hospitalization. In such cases, we are authorized to award temporary disability compensation commencing from the time the worker is actually hospitalized or undergoes outpatient surgery.

After careful consideration of the evidence, we conclude claimant's hospitalization on March 17 and 18 does not satisfy the criteria set forth in ORS 656.278(1)(a) and ORS 438-12-052(2). The medical evidence indicates that no treatment was carried out in the hospital; rather, claimant merely underwent diagnostic testing. We conclude we have no authority to reopen the claim for the payment of temporary total disability compensation. The request for own motion relief is hereby denied.

IT IS SO ORDERED.

CAROL A. FISHER, Claimant
Pozzi, et al., Claimant's Attorneys
Roberts, et al., Defense Attorneys
SAIF Corp Legal, Defense Attorney
James Griffin, Assisant Attorney General

WCB 87-15218 & 87-12543
May 18, 1988
Order on Review

Reviewed by Board Members Ferris and Crider.

Claimant requests review of Referee Wasley's order that upheld the insurers' denials of claimant's occupational disease and industrial injury claims relating to her low back.

ISSUES

1. The compensability of claimant's low back condition.

2. Responsibility for the condition.

FINDINGS OF FACT

Claimant worked for the employer as a public health nurse from July 1972 through February 1978 and from September 1, 1983 (Ex. 4) through May 27, 1987. She worked full time except for the period from September 1, 1983 to July 1, 1985. At the beginning of that period, she worked two days per week. She then gradually increased her hours until July 1, 1985, when she resumed full-time work. Before July 1, 1985, claimant performed a variety of nursing and clerical tasks. On that date, she was made coordinator of two programs, a prenatal program for indigent pregnant women and an auto passenger safety program.

As coordinator of the prenatal program, claimant gave public presentations in various locations. To accomplish this, she had to load her car with materials such as a projector, charts, anatomical models and boxes of pamphlets several times per week. Of these items, the heaviest were the projector, which weighed about 25 pounds, and the boxes of pamphlets, which weighed from 15 to 20 pounds. As coordinator of the safety program, claimant rented child safety seats to the public. In doing this, she regularly carried safety seats to peoples' cars and installed them, usually in the middle of the back seat. The seats weighed about 10 pounds. Claimant's office was in the basement of a county building and she regularly carried the materials for her presentations and the safety seats up and down a narrow, 14-step staircase.

Claimant injured her mid back in 1968 during nursing training when she lifted a patient. She treated briefly with a chiropractor and her symptoms resolved. Claimant injured her mid back a second time in 1984 when she placed a bag of groceries in the back seat of her car. That injury resolved without medical treatment. Claimant first experienced low back pain in late 1985. The pain began without any specific incident and waxed and waned during the next year. She sought no medical treatment and lost no time from work during this period.

Claimant experienced a severe increase in low back pain on November 9, 1986 after an acute back strain which occurred as a result of two off-work exertions. The first was putting firewood into a woodstove. The second involved putting a fitted sheet on a bed. A few hours after these activities, claimant experienced severe back pain and muscle spasms. She was unable to work for approximately two weeks and sought medical treatment from Dr. Nelson, an internist.

Claimant returned to work in late November 1986. She told her coworkers that she had hurt her back off work while making a bed. She continued to experience considerable low back pain during the next six months or so and avoided carrying things up and down the stairs. Her coworkers and later her husband did this for her.

During the week of May 25, 1987, claimant's husband was unable to assist her with the lifting and carrying activities required by her job. Claimant performed these activities herself on May 25, 26 and 27. She wore a back brace during this activity and experienced no immediate increase in low back symptoms. On May 27, claimant came down with the flu. She called in sick on May 28 and experienced nausea and vomiting that day and the following day. While home with this illness, claimant experienced a severe exacerbation of low back pain.

Claimant returned to Dr. Nelson on June 1, 1987. She told him that she thought her increased back pain had resulted from work activity the previous week. She also told him about her bout with the flu. (Tr. 75). Dr. Nelson prescribed conservative treatment. Within a few days, claimant's pain began to radiate into her legs. Dr. Nelson referred her to Dr. Gehling, a neurosurgeon. After a CT scan and nerve conduction studies, Dr. Gehling diagnosed severe mechanical low back pain due to spondylolysis at L5-S1. He recommended continued conservative treatment. Claimant began treating with a chiropractor, Dr. Akridge, on July 27, 1987. Claimant remained off work at the time of the hearing in December 1987.

We accept Dr. Gehling's diagnosis of severe mechanical low back pain due to spondylolysis. Spondylolysis is an abnormality of the facets which may be congenital and can also result from trauma such as a fall on the buttocks or a lifting incident. The condition tends to worsen with time, activity and trauma, resulting in increased low back pain. Claimant's work activity on May 25, 26 and 27, 1987 contributed in part to a worsening of her spondylolysis.

The employer was insured by Liberty Northwest Insurance Corporation from July 1, 1985 through June 30, 1986. The SAIF Corporation covered the employer from July 1, 1986 through the date of the hearing. SAIF denied claimant's condition on both compensability and responsibility grounds on July 13, 1987. Liberty Northwest issued a similar denial on September 28, 1987.

OPINION AND CONCLUSIONS

Compensability

Claimant presents two theories of compensability. The first theory is that her entire period of employment with the employer resulted in a compensable occupational disease. The second is that her work activity on May 25, 26 and 27, 1987 resulted in a compensable industrial injury.

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

Claimant's condition is spondylolysis. The onset of the condition was either congenital or the result of acute trauma. If congenital, the onset had nothing to do with claimant's employment. If traumatic, the onset was the result of an injury rather than a disease. See Harris v. Albertson's, Inc., 65 Or App 254, 256-57 (1983); O'Neal v. Sisters of Providence, 22 Or App 9, 13-17 (1975). Either way, the onset of the condition is not compensable as an occupational disease. To establish the compensability of her condition on an occupational disease theory, therefore, claimant must prove that her work activity was the major contributing cause of a pathological exacerbation of the underlying condition. This presents a complex medical question requiring expert medical analysis. See Uris v. Compensation Department, 247 Or 420, 424-26 (1965); Kassahn v. Publishers Paper Co., 76 Or App 105, 109 (1985).

The only medical opinion which indicates that claimant's work activity was the major contributing cause of a pathological worsening of her spondylolysis was that of Dr. Akridge, the

chiropractor who began treating her in July 1987. He opined in testimony at the hearing that claimant's work activities had gradually worsened her condition from late 1985 to May 1987, when the condition became totally debilitating. (Tr. 16-19). From his testimony on cross-examination, however, it is clear that he was unaware of claimant's off-the-job injury in November 1986 or her bout with the flu in May 1987. (See Tr. 27-34). These deficiencies in the history provided to Dr. Akridge greatly diminished the probative value of his opinion, see Somers v. SAIF, 77 Or App 259, 263 (1986), and he was not rehabilitated on redirect examination. (See Tr. 40-42). There being no other medical support for claimant's occupational disease theory, we conclude that claimant has failed to prove a compensable occupational disease.

To establish a compensable industrial injury, claimant has the burden of proving that a work event or series of events within a discrete time period was a material contributing cause of her disability or need for medical services. See Harris v. Albertson's, Inc., supra, 65 Or App at 256-57; Valtinson v. SAIF, 56 Or App 184, 187-88 (1982). "Material contributing cause" means a substantial cause, but not necessarily the sole cause or even the most significant cause. See Van Blokland v. Oregon Health Sciences University, 87 Or App 694, 698 (1987); Lobato v. SAIF, 75 Or App 488, 492 (1985). Claimant need not show a pathological exacerbation of her underlying condition in order to prevail on an industrial injury theory. Harris v. Albertson's, Inc., supra, 65 Or App at 256-57.

The first question which we must answer in addressing claimant's industrial injury theory is whether the worsening of a condition which allegedly results from three full days of work activity can properly be characterized as an industrial injury rather than an occupational disease. In O'Neal v. Sisters of Providence, supra, 22 Or App at 16, the court adopted a two-pronged test for distinguishing between industrial injuries and occupational diseases:

> "'What set[s] occupational diseases apart from industrial 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 not] sudden in onset.'" Id. at 16 (alterations in original) (quoting 1A A. Larson, The Law of Workmen's Compensation § 41.31 (1973)).

This test was later approved by the Supreme Court in James v. SAIF, 290 Or 343, 348 (1981).

We understand the first prong of this test to require a retrospective estimation of the likelihood that the medical condition claimed would result from the kind, rate and duration of activity or exposure alleged to be the cause of the condition. See O'Neal v. Sisters of Providence, supra, 22 Or App at 17; 1B A. Larson, The Law of Workmen's Compensation §§ 37.20, 38.83(f) (1987). If the condition claimed was not unlikely to follow such activity or exposure, an occupational disease is suggested. If the condition claimed was not expected from such activity or exposure, an industrial injury is indicated.

The second prong of the test requires definition of the phrase "sudden in onset." In Valtinson v. SAIF, supra, 56 Or App at 188, the court ruled that the onset of a condition is "sudden" if it occurs as a result of a "discrete period" of work activity or exposure. It held that the activity of driving a vehicle for several hours during a single workday satisfied this requirement. Id. Professor Larson states that most jurisdictions recognize a period of several days to be sufficiently discrete to satisfy the requirement. 1B A. Larson, The Law of Workmen's Compensation § 39.20 (1987). But cf. Hall v. Home Insurance Co., 59 Or App 526, 528-29 (1982) (occupational disease rules applied to gradually deteriorating low back condition which suddenly worsened after two full days of work activity).

In the present case, we conclude that the kind, rate and duration of activity performed by claimant was unlikely to result in the condition claimed. We also conclude that a period of three full days of such activity was sufficiently discrete to satisfy the "sudden in onset" requirement. We hold, therefore, that claimant's claim relating to her work activity on May 25, 26 and 27, 1987 is one for industrial injury rather than occupational disease. Accordingly, claimant must prove that her work activity on those days was a material contributing cause of her subsequent disability and need for medical services. Because the worsening of claimant's condition was not directly associated with any particular incident and occurred while claimant was at home with the flu, the question of the contribution of claimant's work activity to the worsening is a complex medical question requiring expert medical analysis. See Uris v. Compensation Department, supra, 277 Or at 424-26; Kassahn v. Publishers Paper Co., 76 Or App at 109.

There are two medical opinions which support claimant's industrial injury claim. One opinion was by Dr. Akridge. He opined as an alternative to his occupational disease theory that the worsening of claimant's condition in May 1987 was caused by her work activity on May 25, 26 and 27, 1987. (See Tr. 19-21). As previously noted, however, Dr. Akridge was not aware of claimant's bout with the flu until the date of the hearing and he was not rehabilitated after learning of it. His opinion, therefore, is of limited probative value. See Somers v. SAIF, supra, 77 Or App at 263.

The other opinion was by Dr. Nelson. He opined:

> "Although [claimant] has had problems with her back intermittently in the past, it appears that part at least of the precipitating recently was related to her employment. It should be noted that this is a historical nature [sic] in that there were no other physical stresses going on at the time she began to have her progressive difficulty recently."

Dr. Nelson's opinion is difficult to interpret because of several ambiguities. First, the opinion does not specify the period of "employment" which contributed to the worsening of claimant's low back condition. Second, it does not quantify that contribution precisely. Third, it does not expressly discuss claimant's bout with the flu.

Regarding the first ambiguity, claimant returned to Dr. Nelson with increased low back pain on June 1, 1987. She told him that she thought her increased pain was due to lifting and carrying activity at work on May 25, 26 and 27, 1987. Given this context for Dr. Nelson's opinion, we read the word "employment" in the opinion as a reference to claimant's work activity on May 25, 26 and 27, 1987. This reading is bolstered by Dr. Nelson's allusion to recent "precipitating" events and his contrast of her recent low back difficulties with her earlier difficulties.

Regarding the second ambiguity, Dr. Nelson's opinion does not employ the phrase "material contributing cause." The opinion states simply that claimant's employment activity was responsible at least in part for the worsening of her condition. We read this statement as saying that claimant's employment activity was a substantial cause, although perhaps not the major cause, of her disability and need for medical services. This is sufficient to satisfy the definition of "material contributing cause" despite the absence of the phrase itself. See McClendon v. Nabisco Brands, Inc., 77 Or App 412, 417 (1986).

The third ambiguity concerns Dr. Nelson's statement that there were no "physical stresses" other than claimant's employment activity that could account for the worsening of her condition without commenting expressly concerning the vomiting associated with her bout with the flu. Claimant testified that she told Dr. Nelson about her illness when she sought treatment from him on June 1, 1987. We accepted this testimony in making our findings of fact. In view of this finding, we read Dr. Nelson's report as saying that claimant's bout with the flu did not involve physical stresses sufficient by themselves to account for the worsening of claimant's low back condition.

To summarize, Dr. Nelson's opinion is that claimant's work activity on May 25, 26 and 27, 1987 was a material contributing cause of her subsequent disability and need for medical services. There are no opinions to the contrary. Dr. Nelson's opinion is sufficient, therefore, to satisfy claimant's burden of proving a compensable industrial injury.

Responsibility

Claimant sustained an industrial injury after performing work activity on May 25, 26 and 27, 1987. SAIF, the second insurer, was on the risk at that time. Claimant had sustained no previous industrial injury while Liberty Northwest was on the risk. Under these circumstances, Liberty Northwest can only be found responsible if the industrial injury in May 1987 was due solely to work activity performed before July 1, 1986, when SAIF came on the risk. See FMC Corp. v. Liberty Mutual Insurance Co., 70 Or App 370, 374 (1984), amplified, 73 Or App 223, rev den 299 Or 203 (1985); cf. Geentry v. Hyster, Inc., 23 Or App 146 (1975) (occupational disease suddenly manifested itself while claimant was off work). The record does not support such a conclusion. SAIF, therefore, is responsible.

Claimant's attorney is entitled to a fee under ORS 656.386(1) for services at the hearing and on Board review. A fee awarded under ORS 656.386(1) is an "assessed fee" within the meaning of OAR 438-15-005(2). The Board may not award an assessed

fee until it receives and considers a statement of services from the claimant's attorney. OAR 438-15-010(5). To date, no such statement of services has been received. No fee, therefore, can be awarded for claimant's attorney at this time.

ORDER

The Referee's order dated December 28, 1987 is reversed in part. The SAIF Corporation's denial dated July 13, 1987 is set aside and the claim is remanded to SAIF for processing. The remainder of the Referee's order is affirmed. Counsel for Liberty Northwest Insurance Corporation is authorized to charge a client-paid fee of up to $1,012 for services on Board review.

IRENE HILLIKER, Claimant
Coons & Cole, Claimant's Attorneys
Schwabe, et al., Defense Attorneys

Own Motion 88-0097M
May 18, 1988
Own Motion Order

The insurer has submitted to the Board claimant's claim for an alleged worsening of her May 18, 1977 industrial injury. Claimant's aggravation rights have expired. The insurer opposes reopening for the payment of temporary total disability as it contends claimant has not been a member of the work force since her 1977 injury. It also contends that since claimant did not raise this particular issue at her October 1987 hearing, she cannot do so now.

Claimant underwent inpatient surgery to her left shoulder on January 7, 1988. Pursuant to ORS 656.278(1)(a), we may exercise our "Own Motion" authority when we find that there is a worsening of a compensable injury that requires either inpatient or outpatient surgery or other treatment requiring hospitalization. In such cases, we are authorized to award temporary disability compensation commencing from the time the worker is actually hospitalized or undergoes outpatient surgery.

The insurer contends that claimant has not been a member of the work force since 1977. It also contends this issue is now res judicata as it was not raised at recent hearing. Claimant has provided the Board with documents proving that she was involved in a business venture until December 1986. The medical evidence indicates claimant treated for her shoulder condition throughout much of 1987 and, in fact, surgery was recommended as far back as April 1987. We conclude that claimant has not permanently removed herself from the work force and is entitled to compensation for temporary total disability during recovery from surgery. Cutright v. Weyerhaeuser Company, 299 Or 290 (1985), and Karr v. SAIF, 79 Or App 250 (1986).

Accordingly, claimant's claim is reopened with temporary total disability compensation to commence January 7, 1988 and to continue until claimant returns to her regular work at her regular wage or is medically stationary, whichever is earlier. Claimant's attorney is awarded 25% of the additional compensation granted by this order, not to exceed $500 as a reasonable attorney's fee. Reimbursement from the Reopened Claims Reserve is authorized to the extent allowed under ORS 656.625 and OAR 436, Division 45. When appropriate, the claim shall be closed by the insurer pursuant to OAR 438-12-055.

IT IS SO ORDERED.

GIL T. HINTON, Claimant
Meyers & Terrall, Attorneys
Gary Wallmark (SAIF), Defense Attorney
Carl M. Davis, Assistant Attorney General

WCB 87-00414 & 86-08265
May 18, 1988
Order on Review

Reviewed by Board Members Crider and Ferris.

Claimant requests review of Referee Higashi's order which dismissed his hearing request for failure to appear at hearing or, in the alternative, for abandonment of his claim. We dismiss the request for review for lack of jurisdiction. On review, the sole issue is jurisdiction.

FINDINGS OF FACT

This matter involves consolidated cases wherein claimant requested hearings on two separate denials, one by the SAIF Corporation and the other by the Employers Casualty Company. The Referee dismissed the matter and issued an order to that effect on November 24, 1987. Claimant mailed a handwritten request for review, dated December 9, 1987, to the SAIF Corporation. He did not mail a review request to the Board. SAIF received the review request on December 11, 1987, and forwarded a copy of the request to the Board, where it was received on January 7, 1988.

The request was not accompanied by an acknowledgement of service or a certificate of personal service by mail upon the employer or the Employers Casualty Company. We are unable to find that statutory notice of the review request was mailed to, or actual notice received by, the employer or the Employers Casualty Company within 30 days after mailing of the Referee's dismissal order.

CONCLUSIONS AND OPINION

A referee's order is final unless, within 30 days after the date on which a copy of the order is mailed to the parties, one of the parties requests board review under ORS 656.295. ORS 656.289(3). Requests for board review shall be mailed to the board and copies of the request shall be mailed to all parties to the proceeding before the referee. ORS 656.295(2). Compliance with ORS 656.295 requires that statutory notice of the request for review be mailed or actual notice be received within the statutory period. Argonaut Insurance Co.v. King, 63 Or App 847 (1983). We apply these requirements strictly, because the Court of Appeals has firmly held that compliance with ORS 656.289(3) and 656.295(2) is "an irreducible hard core of necessary function that cannot be dispensed with in any orderly investigation of the merits of a case." Argonaut Insurance Co. v. King, supra, 63 Or App at 851-52, quoting Nollen v. SAIF, 23 Or App 420, 423 (1975), rev den (1976).

Here, claimant has failed to comply with the notice requirements in two respects. First, he failed to mail a request for review to the Board. Indeed, the Board received actual notice of the request only after the 30-day limitations period had expired. Second, claimant failed to mail a copy of the review request to the Employers Casualty Company, one of the parties to the proceeding before the Referee. There is no evidence that Employers Casualty received actual notice of the request within the limitations period. We conclude, therefore, that we lack

jurisdiction to review the Referee's order, which has become final by operation of law. See ORS 656.289(3); Argonaut Insurance Co. v. King, supra.

We are mindful that claimant has requested review without the benefit of legal representation. We further realize that an unrepresented party is not expected to be familiar with administrative and procedural requirements of the Workers' Compensation law. Yet, we are not free to relax a jurisdictional requirement, particularly in view of Argonaut Insurance Co. v. King, supra. See Karen K. Vansanten, 40 Van Natta 63 (1988); Robert G. Ebbert, 40 Van Natta 67 (1988).

Accordingly, the request for Board review is dismissed.

IT IS SO ORDERED.

BEVERLY LANE, Claimant
EBI, Insurance Carrier

Own Motion 88-0221M
May 18, 1988
Own Motion Order

The insurer has submitted to the Board claimant's claim for an alleged worsening of her August 24, 1979 industrial injury. Claimant's aggravation rights have expired. The insurer opposes reopening of this claim for payment of temporary total disability compensation as it feels it does not have enough information upon which to base a decision in claimant's favor.

Pursuant to ORS 656.278(1)(a), we may exercise our "Own Motion" authority when we find that there is a worsening of a compensable injury that requires either inpatient or outpatient surgery or other treatment requiring hospitalization. The medical evidence submitted by EBI indicates that claimant fell on January 18, 1988. Conservative treatment was apparently provided. The medical evidence fails to demonstrate that claimant was hospitalized for treatment or that surgery was required, either inpatient or outpatient. We also find no evidence to show that claimant was a part of the work force as required in Cutright v. Weyerhaeuser Company, 299 Or 290 (1985), and Karr v. SAIF, 79 Or App 250 (1986). We conclude we have no authority to reopen this claim for temporary total disability compensation. The request for own motion relief is hereby denied.

IT IS SO ORDERED.

CYNTHIA K. OLIVER, Claimant
Brian R. Whitehead, Claimant's Attorney
David O. Horne, Defense Attorney

WCB 87-19385
May 18, 1988
Order Denying Motion to Dismiss

The insurer has requested review of Referee Hettle's March 25, 1988 order. Claimant has moved for an order dismissing the request on the ground that it was untimely filed. The motion is denied.

FINDINGS

The Referee's order issued March 25, 1988. The insurer's request for review was mailed to the Board by certified mail on April 25, 1988, which was a Monday. The request was received by the Board on April 26, 1988. Included with the request was a certificate of personal service by mail, indicating that a copy of the request had been mailed to claimant's attorney on April 25, 1988.

We find that the request was mailed to the Board and to claimant's attorney on April 25, 1988.

CONCLUSIONS

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

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

Here, the 30th day after the Referee's March 25, 1988 order was April 24, 1988, a Sunday. Thus, the last day to timely file a request for Board review was Monday, April 25, 1988. See ORS 174.120. Since claimant's request was mailed by certified mail on April 25, 1988, it is timely. See OAR 438-05-046(1)(b).

Furthermore, statutory notice of the insurer's request for review was timely mailed. No contention has been made that claimant has been prejudiced by not directly receiving a copy of the insurer's request for review. Absent a showing of prejudice to a party, timely service of a request for Board review on the attorney for a party is adequate compliance with ORS 656.295(2) to vest jurisdiction in the Board. Argonaut Insurance v. King, supra, page 850-51; Nollen v. SAIF, 23 Or App 420, 423 (1975), rev den (1976); Robert C. Jaques, 39 Van Natta 299 (1987).

Accordingly, the motion to dismiss is denied. A hearing transcript shall be ordered. Upon receipt of the transcript, copies will be provided to the parties. Thereafter, a briefing schedule shall be implemented.

IT IS SO ORDERED.

STEVE CHAMBERS, Claimant
Welch, et al., Claimant's Attorneys
SAIF Corp Legal, Defense Attorney

Own Motion 88-0222M
May 19, 1988
Denial of Issuance of Order Designating a Paying Agent (ORS 656.307)

The Compliance Division has notified the Board that it is prepared to issue an order designating a paying agent under ORS 656.307 and OAR 436-60-180. Each of the employers/insurers have provided their written acknowledgment that the only issue is responsibility for claimant's otherwise compensable claim. Claimant's aggravation rights under his claim with Liberty

Northwest Insurance Corporation have expired. Thus, that claim is subject to ORS 656.278.

Pursuant to OAR 438-12-032(3), the Board shall notify the Compliance Division that it consents to the order designating a paying agent, if it finds that the claimant would be entitled to own motion relief if the own motion insurer is the party responsible for payment of compensation. The Board may exercise its own motion jurisdiction if there is a worsening of a compensable injury that requires either inpatient or outpatient surgery or other treatment requiring hospitalization. ORS 656.278(1)(a). In such cases, the Board may authorize the payment of temporary disability compensation from the time the worker is actually hospitalized or undergoes outpatient surgery until the worker's condition becomes medically stationary, as determined by the Board. id.

The record fails to establish that there has been a worsening of claimant's compensable injury requiring either inpatient or outpatient surgery or other treatment requiring hospitalization. Consequently, claimant would not be entitled to own motion relief if the own motion insurer is found responsible for claimant's current condition.

Because the Board presently lacks Own Motion jurisdiction to award temporary disability compensation, it is without authority to consent to an order designating a paying agent. However, since responsibility for claimant's current condition is the only issue in dispute, the Board recommends the issuance of an order designating a paying agent pursuant to ORS 656.307(1)(b) for the payment of claimant's medical services. See OAR 436-60-180(14).

IT IS SO ORDERED.

JOHNNY L. HENSHAW, Claimant
Dames & Dames, Claimant's Attorneys
John L. Hilts, Attorney
Rankin, VavRosky, et al., Defense Attorneys

WCB 84-11637 & 84-11638
May 19, 1988
Order on Review

Reviewed by Board Members Johnson and Crider.

Claimant requests review of Referee Mongrain's order that upheld the insurer's denial of claimant's aggravation claim for his low back and head condition. The insurer cross-requests review, arguing that the Referee erred in denying its motion to dismiss claimant's hearing request as untimely. On review, the issues are jurisdiction and aggravation.

We affirm and adopt the order of the Referee. We write only to address the insurer's assertions that the Referee lacked jurisdiction to consider the merits of claimant's aggravation claim.

FINDINGS

Claimant's aggravation rights expired November 6, 1984. No medical report submitted between April 23, 1982, the last arrangement of compensation, and November 6, 1984, the expiration of claimant's aggravation rights, suggested that claimant needed treatment for more than his continuing conditions. However, claimant filed a hearing request on November 3, 1984, contending that his compensable condition had become aggravated since the last arrangement of compensation. No response from the insurer was forthcoming.

On February 28, 1985, claimant filed a supplemental request for hearing concerning the issues of aggravation, permanent disability, and vocational rehabilitation. Claimant also attached an application to schedule a hearing. In July 1985, the parties entered into an "Interim Settlement," resolving, on a temporary basis, certain specified issues concerning diagnostic procedures and time loss benefits. The parties expressly agreed to preserve the issues raised by claimant's previous hearing requests.

On April 22, 1986, the insurer issued a denial, which among other actions, denied that claimant's condition resulting from his 1977 head and low back injury claim had worsened. In accordance with its decision, the insurer further advised claimant that it opposed any reopening of the claim under the Board's Own Motion authority. Claimant did not request a hearing concerning this denial.

On de novo review of the medical and lay evidence, we find that claimant has failed to prove that his compensable condition has worsened since the last arrangement of compensation.

CONCLUSIONS

After the last arrangement of compensation an injured worker is entitled to additional compensation for worsened conditions resulting from the original injury. ORS 656.273(1). The claim for aggravation must be filed within five years after the first determination is made. ORS 656.273(4)(a). Notice of an aggravation claim must show more than a need for palliative treatment for continuing conditions. Krajacic v. Blazing Orchards, 84 Or App 127, 130 (1987), remanded on other grounds 304 Or 436 (1987), adhered to on recon 90 Or App 593 (April 20, 1988); Ronald L. McMahill, 39 Van Natta 399 (1987).

Here, the medical reports submitted between April 23, 1982, the last arrangement of compensation, and November 6, 1984, the expiration of his aggravation rights, indicate a need for palliative treatment for claimant's continuing conditions. Consequently, we conclude that these reports do not constitute a claim for aggravation. Yet, claimant filed a hearing request on November 3, 1984, prior to the expiration of his aggravation rights, contending that his compensable condition had become aggravated since the last arrangement of compensation. We consider this request to represent a claim for aggravation. However, the hearing request was premature. Syphers v. K-W Logging, Inc., 51 Or App 769, rev den 291 Or 151 (1981).

When no response from the insurer was forthcoming, claimant then filed a February 28, 1985 supplemental request for hearing, attaching an application to schedule a hearing. We treat this later submission as a timely request for hearing concerning the insurer's "de facto" denial of claimant's timely aggravation claim. Inasmuch as claimant filed a claim for aggravation prior to the expiration of his aggravation rights and since he timely requested a hearing regarding the insurer's "de facto" denial of his claim, we conclude that the Referee had jurisdiction to consider the merits of the aggravation claim.

The insurer correctly asserts that claimant did not file a hearing request from its April 1986 denial of claim reopening.

Yet, for the reasons discussed above, the merits of the claim submitted prior to the expiration of claimant's aggravation rights were already before the Referee. Furthermore, to the extent that the denial pertained to claimant's then-current condition, this "claim reopening" issue was subject to the Board's Own Motion authority, rather than the Hearings Division, and has been addressed by our Own Motion Order, issued this date.

Finally, as previously mentioned, we agree with the Referee that the medical and lay evidence fails to establish that claimant's condition resulting from his compensable August 1977 injury has worsened since the last arrangement of compensation.

ORDER

The Referee's order dated December 2, 1986 is affirmed. The insurer's counsel is authorized to charge a client paid fee, not to exceed $105.

LESTER W. BOCHART, Claimant
Drakulich & Carlson, Claimant's Attorneys
David O. Horne, Defense Attorney

WCB 85-04847
May 24, 1988
Order on Reconsideration

Claimant has requested reconsideration of the Board's Order on Review dated November 27, 1987, which awarded his attorney an assessed fee of $700 for prevailing against the insurer's appeal of the Referee's award of permanent total disability. Claimant contends that he is entitled to an attorney fee in excess of that granted by the Board. Specifically, claimant's attorney seeks an assessed fee of $4,556 for his services on review. On December 28, 1987, the Board's order was abated and the insurer was granted an opportunity to respond. Having received the insurer's response, the Board has reconsidered the matter.

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. ORS 656.382(2); see also OAR 438-15-070.

In determining the reasonableness of an assessed fee, several factors must be considered. OAR 438-15-010(6); see also Barbara A. Wheeler, 37 Van Natta 122, 123 (1987). These factors include: (1) the time devoted to the case; (2) the complexity of the issue(s) presented; (3) the value of the interest involved; (4) the skill and standing of counsel; (5) the nature of the proceedings; (6) the results secured; (7) the risk that the attorney's efforts may go uncompensated; and (8) the assertion of frivolous issues or defenses.

After further review, we conclude that claimant's attorney's fee award should be increased. The record in this case consisted of a 705 page transcript and over 100 exhibits. Claimant's attorney devoted 53.6 hours of his time to preparing and writing a 43-page Respondent's Brief. The brief was well written and provided a thorough analysis of the facts and relevant points of law. The issue presented (i.e., permanent total disability) involved several complex medical, social, and vocational questions. Lastly, claimant's attorney secured a good result for claimant.

The insurer responds that claimant was writing a respondent's brief, which accepted the Referee's statement of facts. In addition, the insurer contends that the amount of time claimant's attorney devoted to merely reviewing the transcript, was excessive. The insurer suggests that an attorney fee in the range of $1,500 would adequately compensate claimant's attorney.

After reconsideration in light of the factors set forth in OAR 438-15-010(6), supra, we conclude that an assessed fee of $3,500 adequately and appropriately compensates claimant's attorney for his services on Board review. Accordingly, as modified herein, we adhere to and republish our former order, effective this date.

IT IS SO ORDERED.

LINDA L. CARROLL, Claimant
Mark Bronstein (SAIF), Defense Attorney

WCB 87-17793
May 24, 1988
Order Denying Motion to Dismiss

The SAIF Corporation has moved for an order dismissing claimant's request for Board review on the ground that a copy of the request was not served on all parties. We deny the motion.

FINDINGS

The Referee's order issued February 8, 1988. On March 8, 1988, the Board received claimant's March 7, 1988 request for Board review. On March 9, 1988, the Board mailed a computer-generated letter to all parties acknowledging the request.

The request for review did not include an acknowledgment of service or a certificate of personal service by mail upon any of the parties who appeared at the hearing and their attorneys. See OAR 438-05-046(2)(b); 438-11-005(3). However, the March 7, 1988 request for review did indicate that a copy of the request had been provided to the employer, SAIF's corporate headquarters, and SAIF's branch office. All of the aforementioned entities had been listed in the Referee's order as parties to the hearing. SAIF's counsel, who is located at SAIF's branch office, did not receive a copy of the request.

We find that the request was filed and copies of the request were mailed to the parties within 30 days of the Referee's order.

CONCLUSIONS

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

"Party" means a claimant for compensation, the employer of the injured worker at the time of injury and the insurer, if any, of such employer. ORS 656.005(19). Attorneys are not

included within the statutory definition of "party." Robert Casperson, 38 Van Natta 420, 421 (1986).

Here, claimant timely filed a request for Board review of the Referee's order. See ORS 656.289(3). Furthermore, included with claimant's request, was her representation that copies had been sent to the other parties. Neither the employer nor a representative from SAIF's main branch disputes this representation. Under these circumstances, we find that claimant timely mailed a copy of her request for Board review to all parties to the proceeding. See ORS 656.295(2); Argonaut Insurance Co. v. King, supra. Consequently, we conclude that we have jurisdiction to consider her request for review.

Accordingly, the motion to dismiss is denied. SAIF's respondent's brief shall be due 14 days from the date of this order. Claimant's reply brief, if any, shall be due seven days from the date of mailing of SAIF's brief. Thereafter, this case will be docketed for Board review.

IT IS SO ORDERED.

RONALD G. HANSEN, Claimant
Hayner, Stebbins, et al., Claimant's Attorneys
Foss, Whitty, et al., Defense Attorneys

WCB 83-03734 & 84-09893
May 24, 1988
Order on Remand

This matter is before the Board on remand from the Court of Appeals. Hansen v. Weyerhaeuser Company, 89 Or App 349 (1988). The court has concluded that claimant's second stay at the pain center is compensable. Consequently, this case has been remanded for the "payment of medical benefits for the period November 26 to December 13, 1984, at the Western Pain Center."

Accordingly, the self-insured employer is directed to pay medical benefits from November 26, 1984 to December 13, 1984, the period of time which coincides with claimant's second stay at the Western Pain Center.

IT IS SO ORDERED.

JOHN SCRIVNER, Claimant
Pozzi, et al., Claimant's Attorneys
Moscato & Byerly, Defense Attorneys

WCB 87-12102
May 24, 1988
Order of Dismissal

The self-insured employer has moved the Board for an order dismissing claimant's request for review on the ground that the request was untimely filed and that notice of the request was not timely provided to the other parties. The motion is granted.

FINDINGS

The Referee's order issued March 30, 1988. Claimant's request for review, dated May 2, 1988, was received by the Board on May 3, 1988. The request included a certificate of personal service by mail upon the employer, its processing agent and its attorney. The certificate indicated that a copy of the request had been mailed to the employer and its representatives on May 2, 1988.

The request for Board review was filed more than 30 days after the date of the Referee's order. Furthermore, neither the employer nor its representatives received notice of the request for review within 30 days after the Referee's order.

CONCLUSIONS

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

Here, the 30th day after the Referee's March 30, 1988 order was April 29, 1988. Inasmuch as claimant's request for Board review was filed after April 29, 1988, it was untimely. Moreover, neither the employer nor its representatives were timely provided with, 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 v. King, supra.

Accordingly, the request for Board review is dismissed.

IT IS SO ORDERED.

LELAND SMITH, Claimant
Huffman, et al., Claimant's Attorneys
SAIF Corp Legal, Defense Attorney

Own Motion 88-0308M
May 24, 1988
Own Motion Order

SAIF Corporation has submitted to the Board claimant's claim for an alleged worsening of his June 14, 1977 industrial injury. Claimant's aggravation rights have expired. SAIF has authorized the surgery and recommends that the Board reopen the claim for the payment of temporary total disability compensation.

The Board, by order dated April 15, 1988, denied claimant's earlier request for own motion relief. Claimant now shows that surgery is necessary for his compensable condition and again asks that the claim be reopened for the payment of benefits. Pursuant to ORS 656.278(1)(a), we may exercise our "Own Motion" authority when we find that there is a worsening of a compensable injury that requires either inpatient or outpatient surgery or other treatment requiring hospitalization. In such cases, we are authorized to award temporary disability compensation commencing from the time the worker is actually hospitalized or undergoes outpatient surgery.

Following our review of this record, we are persuaded that claimant's compensable injury has worsened requiring surgery. Accordingly, claimant's claim is reopened with temporary total disability compensation to commence the date of the surgery and to continue until claimant returns to his regular work at his regular wage or is medically stationary, whichever is earlier. Reimbursement from the Reopened Claims Reserve is authorized to the extent allowed under ORS 656.625 and OAR 436, Division 45. When appropriate, the claim shall be closed by the insurer pursuant to OAR 438-12-055.

IT IS SO ORDERED.

BERRELL D. VINYARD, Claimant
Bechtold & Laird, Claimant's Attorneys
Brian L. Pocock, Defense Attorney

WCB 86-12091
May 24, 1988
Order on Review

Reviewed by Board Members Johnson and Crider.

The self-insured employer requests review of Referee Brown's order that: (1) set aside its partial denial of medical services for claimant's lumbar spine condition; and (2) set aside its denial of reimbursement of mileage incurred for medical treatment. We affirm.

ISSUES

(1) Compensability of chiropractic treatment for claimant's lumbar spine condition.

(2) Reimbursement for claimant's mileage expenses incurred for medical treatment.

FINDINGS OF FACT

Claimant was injured in a motor vehicle accident on December 2, 1977. Claimant was a passenger in the employer's company bus. The bus hit another car, went down a ten foot bank and eventually hit a culvert. Claimant sustained compensable injuries to his lumbar and cervical spine.

Claimant felt immediate pain in his neck and low back. He sought medical treatment that same day and was diagnosed as having a strain of the lumbar and cervical spine.

Claimant has been treating his lumbar spine condition with Dr. Harper, chiropractor, since June 1978. Dr. Harper is the only chiropractic physician on the "South Coast" who provides 'Direct Non-Forced Technique' treatment (DNFT). Although there are various schools of chiropractic medicine, some favoring manipulative treatment and some more passive care such as DNFT, DNFT is recognized in the chiropractic profession as a form of treatment.

This treatment is palliative. It has provided claimant symptomatic relief on a twice-per-month basis for nine years. These treatments have relieved his pain and allowed him to continue working.

The employer paid claimant's round trip mileage to receive these treatments from June 1978, until September 30, 1985. After September 30, 1985, the employer stopped paying mileage.

On July 25, 1986, claimant underwent an independent medical examination performed by Dr. Howell, osteopath. On August 27, 1986, the employer issued its partial denial of claimant's lumbar spine condition. It did not deny claimant's cervical spine condition.

DNFT treatment provided by Dr. Harper is a recognized method of chiropractic treatment.

Claimant is a credible witness.

Dr. Fechtel reviewed claimant's medical records, but did not examine him at any time.

CONCLUSIONS OF LAW AND OPINION

(1) Compensability of treatment for claimant's lumbar spine condition.

The employer contends that the type of chiropractic treatment claimant receives from Dr. Harper is neither reasonable and necessary nor related to his compensable injury.

In order to prove compensability of medical services, claimant must prove they are both reasonable and necessary as a result of his original compensable injury. Wetzel v. Goodwin Bros., 50 Or App 101 (1981). ORS 656.245 indicates that medical services ought to be provided "for conditions resulting from the injury for such period as the nature of the injury or the process of the recovery requires, including such medical services as may be required after determination of permanent disability." OAR 436-10-040(1)(a) states that services which are unnecessary or inappropriate according to accepted professional standards are not reimbursable.

Here, the type of treatment provided by Dr. Harper is a recognized method of treatment preferred by some qualified chiropractors. That Dr. Fechtel, himself, does not prescribe such nonmanipulative treatment, renders it neither unorthodox nor inappropriate.

Dr. Fechtel opined that the type of injury claimant sustained always resolves within a period of three months. He dismissed a causal relationship between the car accident and claimant's low back complaints. He did not, however, offer a well-reasoned opinion as to why claimant's symptoms are not related to the accident. Moreover, Dr. Fechtel testified that he considered claimant's low back condition noncompensable because claimant was asymptomatic for a period of time before he began treating with Dr. Harper. However, claimant credibly testified that he had not been asymptomatic. Inasmuch as Dr. Fechtel's opinion is neither well-reasoned nor based on a complete and accurate history, we find his opinion unpersuasive.

Dr. Howell could not explain the etiology of claimant's low back spasms. He focused his examination on claimant's sacroiliac rather than specifically on claimant's low back. Dr. Howell did note, however, that there was a 60 percent narrowing of the L4-L5 region of claimant's lumbar spine as well as bony protrusions and bone spurs. He opined that these abnormalities in claimant's spine were not related to the injuries incurred in the accident. He offered no explanation of the origin of these abnormalities.

Dr. Harper, claimant's treating chiropractor, has treated claimant for a lumbar condition that is consistent with the abnormalities found by Dr. Howell. Claimant never complained of pain in his sacroiliac and testified that he received treatment from Dr. Harper for his low back. Dr. Harper opined that claimant's ongoing symptoms are a direct result of his work related car accident.

The treating physician's opinion is entitled to great weight lacking persuasive reason to do otherwise. Weiland v. SAIF, 74 Or App 317 (1985). In the instant case, we are persuaded by Dr. Harper's opinion that claimant's current symptoms are a direct result of his injury, as well as reasonable and necessary. Both Dr. Fechtel and Dr. Howell's opinions are flawed. Dr. Fechtel did not have accurate information and therefore, incorrectly thought claimant had been asymptomatic before he sought treatment from Dr. Harper. Dr. Howell did not focus on the area where claimant experiences pain and offered no explanation as to why the abnormalities found in the pain producing lumbar area were not related to claimant's accident.

Consequently, we conclude that ongoing chiropractic treatments are reasonable and necessary.

(2) Reimbursement for claimant's mileage expenses incurred for medical treatment.

Dr. Harper is the only doctor on the "South Coast" who provides DNFT treatment. As this treatment is not available near claimant's residence he must travel to receive it. Claimant's mileage expense is compensable. OAR 436-60-050(4).

Claimant's counsel is statutorily entitled to a reasonable, carrier-paid attorney fee for services rendered on Board review. See ORS 656.382(2). Such a fee is defined as an "assessed fee". OAR 438-15-005(2). However, we cannot authorize an assessed fee unless claimant's counsel files a statement of services. See OAR 438-15-010(5). Because no statement of services has been received to date, an assessed fee shall not be authorized.

ORDER

The Referee's order dated December 23, 1987 is affirmed. The Board approves a client paid fee not to exceed $400.

TANA L. WILSON, Claimant
Vick & Gutzler, Claimant's Attorneys
Rick Dawson (SAIF), Defense Attorney

WCB 87-16385
May 24, 1988
Order on Review

Reviewed by Board Members Johnson and Crider.

Claimant requests review of Referee Myers' order that rejected her request for an attorney fee for the SAIF Corporation's allegedly unreasonable failure to close her accepted claim for a nondisabling neck and low back injury.

ISSUES

1. Whether the Referee should have dismissed claimant's request for hearing for lack of jurisdiction.

2. If not, whether claimant's request for an attorney fee for SAIF's failure to close her claim is precluded by the doctrine of res judicata.

3. If not, whether SAIF's failure to close the claim entitles claimant to an attorney fee under ORS 656.382(1).

FINDINGS OF FACT

Claimant compensably injured her low back and neck in January 1981 when she tripped over a box and fell down. She missed no work, but sought medical treatment. Her low back pain resolved within a few weeks. Her neck pain continued and she received occasional treatments for those symptoms from Dr. Buell, an osteopath. SAIF issued a notice of claim acceptance on February 9, 1981, which classified the claim as nondisabling.

In September 1982, claimant experienced an episode of low back pain and sought medical treatment. She was examined by consulting physicians who expressed different opinions regarding the causal relation between her low back pain and the January 1981 industrial injury. SAIF issued an aggravation denial on January 26, 1983 which disavowed any such causal relation. Claimant timely requested a hearing on the denial.

Claimant and SAIF entered into a disputed claim settlement on December 20, 1983. The document was entitled "Stipulation and Order of Settlement Regarding Partial Denial Issued January 26, 1983" and referenced the WCB case number associated with claimant's request for hearing on the denial. After reciting the substance of the dispute between the parties, the document stated in pertinent part:

> "It is the belief of the parties that a bona fide dispute exists as to the compensability of the lumbar or low back condition of the Claimant as it currently exists, without, however, affecting the compensable condition, which shall remain accepted, to-wit: the cervical area; and that the compensability of the lumbar area only shall be settled . . . . The Claimant has been advised by her attorneys and fully understands that the cervical condition will remain compensable, but that the employer and carrier shall have no further responsibility arising out of the January 8, 1981, injury for the current low back condition or any medical bills or disability related thereto."

A later paragraph added: "It is understood and agreed that this settlement is in full settlement of all issues raised or raisable in the above entitled matter." The settlement was approved and claimant's hearing request on SAIF's aggravation denial was dismissed with prejudice by Referee Howell on December 23, 1983.

On October 27, 1987, claimant requested a hearing on the issues of penalties and attorney fees alleging that SAIF had unreasonably failed to close claimant's accepted January 1981 industrial injury claim. As of the time of the hearing on December 22, 1987, SAIF had not issued a notice of claim closure or submitted the claim to the Evaluation Division for closure. Claimant was medically stationary by January 1, 1982 at the latest.

OPINION AND CONCLUSIONS

Jurisdiction

A claim for aggravation of an accepted nondisabling

injury must be filed within five years of the date of injury. ORS 656.273(4)(b). There is no deadline for requesting a hearing on the issues of penalties and attorney fees. See ORS 656.283(1); 656.319.

Claimant requested a hearing in October 1987 on the issues of penalties and attorney fees for SAIF's failure to close her claim for a January 1981 nondisabling injury. The request did not raise and does not involve a claim for aggravation. The limitation of ORS 656.273(4)(b), therefore, is inapplicable. No other time limitation applies to claimant's request for hearing. The Referee, therefore, had jurisdiction to entertain claimant's request.

Res Judicata

The doctrine of res judicata precludes relitigation of claims and issues previously adjudicated. North Clackamas School District v. White, 305 Or 48, 50, modified, 305 Or 468 (1988). "Claim preclusion" is the name for the preclusive effect of a prior adjudication on a claim and "issue preclusion" for the preclusive effect of a prior adjudication on an issue. Id.; Restatement (Second) of Judgments, Introduction at 1-5 (1982).

The rule of claim preclusion is that if a claim is litigated to final judgment, the judgment precludes a subsequent action between the same parties on the same claim or any part thereof. Id. §§ 17-19, 24; see also Carr v. Allied Plating Co., 81 Or App 306, 309 (1986); Million v. SAIF, 45 Or App 1097, 1102, rev den 289 Or 337 (1980). A claim or cause of action is an aggregate of operative facts which compose a single occasion for judicial relief. Carr v. Allied Plating Co., supra, 81 Or App at 310. The number of operative facts viewed as part of the same claim must be determined upon the basis of practical considerations such as whether the facts are related in time, space, origin, or motivation, whether they form a convenient trial unit, and whether their treatment as a unit conforms to the parties' expectations. Restatement (Second) of Judgments § 24(2) (1982); see also Dean v. Exotic Veneers, Inc., 271 Or 188, 192-93 (1975); Carr v. Allied Plating Co., supra, 81 Or App at 310. The effect of the rule of claim preclusion may be limited or eliminated by agreement of the parties. Restatement (Second) of Judgments § 26(1)(a) (1982).

The rule of issue preclusion is that if an issue of fact or law is actually litigated and determined by a valid and final judgment and the determination is essential to the judgment, the determination is conclusive in a subsequent action between the parties, whether on the same or a different claim. North Clackamas School District v. White, supra, 305 Or at 53; Restatement (Second) of Judgments § 27 (1982).

A Referee's order approving a disputed claim settlement and dismissing a claimant's request for hearing is a "judgment" within the meaning of the above rules. See ORS 656.289(4); Proctor v. SAIF, 68 Or App 333, 335-36 (1984); Ronald G. Hill, 37 Van Natta 14, 15 (1985); cf. North Clackamas School District v. White, supra, 305 Or at 51-53 (the doctrine of res judicata generally applies to workers' compensation litigation).

The claim which was the subject of the disputed claim settlement between claimant and SAIF was claimant's low back

aggravation claim. The preclusive effect of the disputed claim settlement was limited by agreement of the parties to all issues raised or raisable in connection with that claim. The subject of the current proceeding is an attorney fee for SAIF's failure to close claimant's original claim. The current proceeding has no connection with claimant's aggravation claim and hence the rule of claim preclusion does not apply. The rule of issue preclusion does not apply because the issue of SAIF's failure to close the original claim was not addressed in and thus was not actually litigated by the disputed claim settlement. Claimant's current request for an attorney fee, therefore, is not barred by res judicata.

Attorney Fees

Attorney fees may be assessed against an insurer which "unreasonably resists the payment of compensation." ORS 656.382(1). Failure to submit a claim for closure after a claimant becomes medically stationary is one form of unreasonable resistance to the payment of compensation. Lester v. Weyerhaeuser Co., 70 Or App 307, 311-12, rev den 298 Or 427 (1984); Georgia-Pacific v. Awmiller, 64 Or App 56, 59-60 (1983). Insurers had a duty under the law in effect at the time of claimant's injury to close nondisabling claims. Former ORS 656.268(3) (effective January 1, 1980; Or Laws 1979, ch 839, §§ 4(3) & 33); Webb v. SAIF, supra, 83 Or App at 390-91. An attorney fee may be assessed for failure to submit a claim for closure even if no compensation ultimately is due at the time of closure. Chester R. Rhodes, 38 Van Natta 1396, 1398 (1986); see also Mischel v. Portland General Electric Co., 89 Or App 140, 143 (1987); Spivey v. SAIF, 79 Or App 568, 572 (1986). But see Davidson v. SAIF, 80 Or App 541, 544 (1986).

Claimant was medically stationary by January 1, 1982 at the latest. SAIF has never taken any steps to close claimant's claim and has offered no explanation for its inaction. We conclude that SAIF's failure to close the claim is unreasonable and that claimant's attorney is entitled to a reasonable attorney fee under ORS 656.382(1).

A fee awarded under ORS 656.382(1) is an "assessed fee" within the meaning of OAR 438-15-005(2). The Board may not award an assessed fee until it receives and considers a statement of services from the claimant's attorney. OAR 438-15-010(5). To date, no statement of the services rendered by claimant's attorney at the hearing or Board levels has been received. No fee, therefore, can be awarded at this time.

ORDER

The Referee's order dated December 29, 1987 is reversed.

ROYCE D. ADAIR, Claimant
Bischoff & Strooband, Claimant's Attorneys
Cowling & Heysell, Defense Attorneys

WCB 86-09629
May 25, 1988
Order on Review

Reviewed by Board Members Ferris and Crider.

The insurer requests review of that portion of Referee Nichols' order that granted claimant permanent total disability, in lieu of a Determination Order award of 40 percent (128 degrees) unscheduled permanent disability for a back, neck and shoulder

injury. On review, the issues are permanent total disability and, alternatively, extent of unscheduled permanent partial disability.

The Board affirms and adopts the order of the Referee.

Because claimant has prevailed over an insurer-initiated request for review, his attorney is statutorily entitled to a reasonable, carrier-paid attorney fee for services rendered on Board review. See ORS 656.382(2) Such a fee is defined as an "assessed fee." See OAR 438-15-005(2). However, we cannot authorize an assessed fee unless claimant's attorney files a statement of services. See OAR 438-15-010(5). Because no statement of services has been received to date, an assessed fee shall not be authorized.

ORDER

The Referee's order dated June 29, 1987 is affirmed. A client-paid fee, not to exceed $859, is approved.

DONALD P. BOND, Claimant
Steven C. Yates, Claimant's Attorney
Rankin, VavRosky, et al., Defense Attorneys

WCB TP-88001
May 25, 1988
Third Party Distribution Order on Reconsideration

Claimant requests reconsideration of the Board's April 25, 1988 Third Party Distribution Order, which found that the paying agency had established its entitlement to a lien for anticipated future medical expenditures. Specifically, the record established that claimant would require routine "followup" care with his treating physician three times a year and a daily dosage of anti-inflammatory medication. Based on claimant's life expectancy, we were persuaded that the present value of this future medical care exceeded the remaining balance of the third party settlement. Consequently, we directed claimant's attorney to distribute the remaining balance to the paying agency.

Enclosing his "uncontroverted" affidavit, claimant contends that he is no longer taking the medication. Furthermore, he asserts that he has no intention of returning to his treating physician, unless his condition worsens.

In submitting his request for reconsideration and accompanying affidavit, claimant provides no explanation as to why he previously acknowledged that "some" medication could be "reasonably expected in the future." Moreover, he does not explain why the information submitted in his affidavit was not presented prior to our order.

We consider such a submission at this time highly suspect, particularly when claimant has already had an ample opportunity to present his case. We note that claimant apparently had a different view of the sufficiency and development of the record before we issued our order. In his last communication to the Board prior to our decision, claimant's counsel stated as follows:

> "[A]s the passage of time should have indicated, we are not going to respond to [the paying agency's] position with regard to the distribution of the third party funds. All the materials have been submitted and we have made our position clear." (Emphasis added).

Under these circumstances, we are not inclined to reopen the record for the submission of claimant's affidavit. First, we consider the present record to be sufficient to sustain judicial review under ORS 656.298. Blackman v. SAIF, 60 Or App 446, 448 (1982). Furthermore, we are persuaded that the evidence submitted at this time was obtainable with due diligence prior to the issuance of our distribution order. To hold otherwise, would potentially expose the Board to an endless string of reconsideration requests and submissions of additional evidence, all designed to respond to conclusions reached by a previous third party order.

Finally, assuming arguendo that the "uncontroverted" affidavit was considered, our decision would remain the same. Considering the untimely submission of claimant's affidavit and comparing it with the present record, particularly the opinion of the treating physician, its inclusion would not alter our conclusion that the paying agency has established its entitlement to the remaining balance of the proceeds from the third party settlement.

Accordingly, the request for reconsideration is granted and our April 25, 1988 order withdrawn. On reconsideration, as supplemented herein, we adhere to and republish our April 25, 1988 Third Party Distribution Order in its entirety, effective this date.

IT IS SO ORDERED.

EARL F. CHILDERS, Claimant
Eddy Swearinger, Claimant's Attorney
Garrett, et al., Defense Attorneys

WCB 85-14969
May 25, 1988
Order on Review

Reviewed by Board Members Crider and Ferris.

The insurer requests review of those portions of Referee Wilson's order which found that: (1) it unilaterally terminated claimant's temporary total disability benefits; (2) it impermissibly issued a denial prior to the closure of claimant's claim; and (3) claimant's small right finger claim had been prematurely closed by a Determination Order. Claimant cross-requests review of those portions of the Referee's order that: (1) declined to assess penalties and attorney fees against the insurer for its allegedly unreasonable termination of his temporary total disability benefits; and (2) declined to award a greater insurer-paid attorney fee. On the request, we affirm; on the cross-request, we reverse and modify.

ISSUES

1. Whether the insurer unilaterally terminated claimant's temporary total disability benefits.

2. Whether the insurer impermissibly issued a denial prior to the closure of claimant's claim.

3. Whether claimant's small right finger claim was prematurely closed by a Determination Order.

4. Whether penalties and attorney fees should be assessed for the insurer's allegedly unreasonable termination of claimant's temporary total disability benefits.

5. Whether claimant's attorney is entitled to a greater insurer-paid fee than that awarded by the Referee.

FINDINGS OF FACT

Claimant sustained a compensable injury to his right little finger in September 1983. The injury resulted in a partial severing of the finger and a protracted period of infection. In addition to this injury, claimant had previously severed part of his right ring finger in 1973.

In March 1984, claimant began serving a prison sentence in the State of Nevada. One month later, the insurer terminated his temporary total disability benefits without explanation. In May 1984, claimant was examined by Dr. Becker, his treating orthopedist. Becker reported that he had never observed a wound like claimant's fail to heal within three to six weeks without wound manipulation. Claimant did not manipulate his wound.

Claimant was released from prison in June 1985. A few months later, claimant returned to Dr. Becker. Becker felt that claimant was unable to work at that time due to his painful right hand. To relieve claimant's symptoms, Becker recommended surgery. On October 2, 1985, claimant underwent surgical revision of his amputation stumps and excision of multiple neuromas. A few days later, Becker reexamined claimant and noted four distinct neuromas located in the incisional area. Becker excised the neuromas and advised claimant to return in one week for suture removal and rehabilitative therapy.

On October 10, 1985, the insurer issued a denial "for reopening of [claimant's] file." One week later, Dr. Becker noted that claimant's wound was healing. Becker recommended rehabilitative therapy three times a week and reduced claimant's pain medication from Tylenol with Codeine to Darvocet. Claimant was to return in one month for a follow-up examination.

On October 28, 1985, a Determination Order issued finding claimant medically stationary on December 16, 1983. In addition, the Determination Order awarded claimant a few months of temporary disability and 65 percent scheduled permanent disability for loss of use of the right little finger.

At the time of the Determination Order, no doctor had reported that claimant was medically stationary or had released him to work.

CONCLUSIONS OF LAW

1. Unilateral Termination

The Referee found that the processing of claimant's claim was improper. We agree.

Claims shall not be closed nor temporary disability benefits terminated if a worker has not become medically stationary or is enrolled in an authorized training program.

Former ORS 656.268(1). An insurer must continue to pay temporary disability benefits unless a worker has been released to return to regular work by his attending physician. Former 656.268(2); see also Volk v. SAIF, 73 Or App 643, 646 (1985); Jackson v. SAIF, 7 Or App 109 (1971). Further, an insurer may not unilaterally terminate an incarcerated worker's temporary disability benefits. Mickey A. Thresher, 39 Van Natta 456, recon. 39 Van Natta 475 (1987); Lloyd O. Fisher, 39 Van Natta 5 (1987).

Here, claimant was incarcerated in March 1984. One month later, the insurer terminated his temporary total disablility benefits without explanation. At that time, no physician had declared claimant medically stationary or released him to return to regular work.

Accordingly, we conclude that the insurer unilaterally terminated claimant's temporary total disability benefits and that such benefits should have continued beyond April 1984 until proper termination pursuant to former ORS 656.268.

2. Preclosure Denial

The Referee set aside the insurer's denial inasmuch as it had issued prior to the closure of claimant's claim. We agree.

A claim may be reopened only after it has first been closed. ORS 656.273; ORS 656.278; see also Roller v. Weyerhaeuser Co., 67 Or App 583 (1984); Safstrom v. Riedel International, Inc., 65 Or App 728 (1983).

Here, the insurer denied "reopening" of claimant's claim. Yet, at the time of the denial claimant's claim remained open and had not been closed. The denial was, therefore, an impermissible preclosure denial and the Referee correctly set it aside.

Furthermore, the insurer issued the denial on the grounds that claimant was allegedly "manipulating the end of [his] finger to maintain an infection in that finger." See ORS 656.156(1). In its denial, the insurer stated that this allegation was supported by "medical information."

However, the only "medical information" of wound manipulation was Dr. Becker's speculative report of May 1984. In response to the insurer's questions regarding alleged wound manipulation, Becker merely stated he had never observed a wound such as claimant's not heal faster without wound manipulation. None of Becker's subsequent reports or notes mentioned suspected wound manipulation. Moreover, claimant's uncontradicted testimony is that he did not manipulate his wound.

On this record, we find that the insurer failed to prove its allegation of wound manipulation.

3. Premature Claim Closure

The Referee found that claimant's claim was prematurely closed. We agree.

Claims shall not be closed if a worker has not become

medically stationary or is enrolled in an authorized training program. Former ORS 656.268(1).

Here, no physician had declared claimant medically stationary prior to the issuance of the October 1985 Determination Order. In fact, Dr. Becker had earlier reported that claimant was unable to work due to pain in his right hand. We conclude, therefore, that the October 1985 Determination Order prematurely closed claimant's claim.

Furthermore, the Referee authorized the insurer to offset "all benefits paid against any sums ordered by the subsequent Determination Order." We find that the Referee's authorization of an offset was incorrect. Whether the insurer is entitled to an offset and how much, if any, should be addressed at the time of claim closure. Fisher, supra, 39 Van Natta at 6; see also Richard M. Deskins, 38 Van Natta 494, 497, recon 38 Van Natta 494 (1986).

4. Penalties and Attorney Fees

Although the Referee found that the insurer's processing of claimant's claim was improper, he declined to assess penalties and attorney fees because there were allegedly no "sums due." We agree that the insurer acted improperly, but disagree that there were no sums due against which to assess penalties and attorney fees.

As we found above, the insurer unilaterally terminated claimant's temporary disability benefits in contravention of former ORS 656.268(1) & (2). Pursuant to ORS 656.262(10), if an insurer unreasonably delays or refuses to pay compensation it shall be liable for an additional amount up to 25 percent of the "amounts then due" plus attorney fees that may be assessed under ORS 656.382. Penalties and attorney fees are appropriate when an insurer unilaterally terminates a worker's temporary disability benefits. See Volk v. SAIF, 73 Or App at 647.

Here, we find that the insurer's unilateral termination of claimant's temporary disability benefits was an unreasonable refusal to pay compensation. ORS 656.262(10). The "amounts then due" for the purpose of assessing penalties and attorney fees are the temporary disability payments that should have continued beyond April 19, 1984, through the date of the hearing.

The insurer argues that in Lloyd O. Fisher, supra, the Board declined to assess penalties and attorney fees for the insurer's unilateral termination of an incarcerated worker's temporary disability benefits. Fisher, however, is distinguishable from the instant case.

In Fisher, the insurer terminated the worker's temporary disability benefits on the basis that he was incarcerated. Unlike Fisher, the instant insurer provided no explanation for its unilateral termination of claimant's temporary disability benefits. In fact, long after it had ceased paying claimant's temporary disability benefits, the insurer admitted in its request for claim closure that the file had "gone unattended for the last year." Under such circumstances, we find that the insurer acted unreasonably.

Therefore, we reverse that portion of the Referee's order that declined to assess penalties and attorney fees for the insurer's unilateral termination of claimants' temporary total disability benefits.

5. Insurer-paid Attorney Fee

The Referee awarded claimant's attorney a $1,750 insurer-paid attorney fee for prevailing on the issue of premature claim closure and for setting aside the insurer's denial. We modify.

In awarding claimant's attorney the above mentioned insurer-paid attorney fee, the Referee stated:

> "Claimant's attorney is entitled to an attorney fee payable by the insurer for his services herein in prevailing upon the issues of premature claim closure and in overturning the denial."

Our Administrative Rules, however, did not provide for an insurer-paid attorney fee for prevailing on the issue of premature claim closure. Rather, the rules provided for an attorney fee equal to 25 percent of a worker's increased temporary total disability compensation not to exceed $750. Former OAR 438-47-030(1). Inasmuch as the Referee's finding that the Determination Order was premature resulted in increased temporary total disability compensation, the Referee should have awarded an attorney fee payable out of claimant's increased compensation.

The Referee was correct, however, in awarding an insurer-paid attorney fee for setting aside the insurer's denial. Former OAR 438-47-020(1)(a). Furthermore, the rules provided for an insurer-paid attorney fee for an insurer's unreasonable resistance to payment of compensation. Former OAR 438-47-020(1)(b); see also ORS 656.262(10). We have found above that the insurer unreasonably resisted the payment of compensation by unilaterally terminating claimant's temporary total disability benefits. Therefore, claimant's attorney is entitled to a reasonable insurer-paid attorney fee.

In sum, we agree with the Referee's award and amount of an insurer-paid attorney fee, but for different reasons. That is, the insurer-paid fee should have been awarded solely for claimant's attorney's services in setting aside the insurer's denial and for the insurer's unreasonable resistance to the payment of compensation. Former 438-47-020(1)(a) & (b). Furthermore, for his services in prevailing on the issue of premature claim closure, we award claimant's attorney an additional attorney fee payable out of claimant's increased temporary total disability compensation. Former 438-47-030(1).

Lastly, claimant's counsel is entitled to a reasonable insurer-paid attorney fee for services rendered on Board review. ORS 656.382(2); see also OAR 438-15-070. Such a fee is defined as an "assessed fee." OAR 438-15-005(2).

In determining the reasonableness of an assessed fee,

several factors must be considered. OAR 438-15-010(6). These factors include: (1) the time devoted to the case; (2) the complexity of the issue(s) presented; (3) the value of the interest involved; (4) the skill and standing of counsel; (5) the nature of the proceedings; (6) the results secured; (7) the risk that the attorney's efforts may go uncompensated; and (8) the assertion of frivolous issues or defenses.

Here, the issues on review are unilateral termination, preclosure denial, premature claim closure, penalties, and attorney fees. Claimant's briefs totaled eleven pages in length. The results secured for claimant are increased temporary total disability compensation, the award of a penalty, and proper closure of his claim.

After considering the factors set forth in OAR 438-15-010(6), as they apply to this case, we conclude that claimant's attorney is entitled to a reasonable assessed fee of $750 for his services rendered on Board review.

ORDER

The Referee's order is reversed in part, modified in part, and affirmed in part. That portion of the Referee's order that declined to assess a penalty is reversed. The insurer is assessed a penalty equal to 25 percent of the amount of temporary total disability owing from April 19, 1984, through December 18, 1986. That portion of the Referee's order that authorized an offset is reversed. That portion of the Referee's order that awarded an insurer-paid attorney fee is modified. In addition to the $1,750 insurer-paid attorney fee awarded by the Referee, claimant's attorney is awarded a fee equal to 25 percent of claimant's increased temporary total disability compensation, not to exceed $750. This additional attorney fee award is to be paid out of, not in addition to, claimant's increased compensation. All remaining portions of the Referee's order are affirmed. Claimant's attorney is awarded an assessed fee of $750 for services on Board review, to be paid by the insurer.

ROBERT W. COOPER, Claimant
Merrily McCabe (SAIF), Defense Attorney
Ann Kelley, Assistant Attorney General

WCB 87-12403 & 87-07354
May 25, 1988
Order on Review

Reviewed by Board Members Ferris and Crider.

Claimant, pro se, requests review of Referee Borchers' order that upheld the SAIF Corporation's denial of claimant's right shoulder and left knee injury claim. On review the issue is compensability. We affirm.

FINDINGS OF FACT

At time of hearing claimant was 28 years old. He filed a claim alleging that he incurred injuries to his right shoulder and left knee as a result of falling down a stairway while employed as an insulator. SAIF issued its denial of compensability on August 21, 1987.

Claimant's co-worker did not see claimant fall down the stairs. He did not find claimant at the bottom of the stairs. The co-worker did not see claimant limp or hear him complain of the alleged accident during the workday.

Claimant's employer did not see claimant limp when he and his co-worker returned to the company office on the date of the alleged injury. Claimant did not report that he had incurred an injury.

The day after his alleged accident, claimant's wife called his employer and inquired about the type of health insurance the employer carried. She stated claimant had hurt his knee and would not be returning to work.

Four days after the alleged injury claimant went to a hospital emergency room. He had complaints of pain in his right shoulder, left knee, neck and back. The emergency room doctor diagnosed contusion and ligamentous strain of the right shoulder and left knee. He prescribed aspirin and pain medication.

Claimant's treating physician is Dr. Anderson, chiropractor. Claimant gave Dr. Anderson a history of his alleged accident which was inconsistent with reports he has given under other circumstances including his testimony. Claimant told Dr. Anderson that after his fall he laid at the the bottom of the stairs for 25 minutes until his co-worker found him. Based upon this history, Dr. Anderson reported that claimant's alleged injury could be the cause of the symptoms he experiences.

We find that claimant's disability and need for medical treatment are not causally related to the alleged accident.

CONCLUSIONS OF LAW AND OPINION

The Referee upheld SAIF's denial, reasoning that claimant failed to establish a causal connection between his condition and employment. She concluded, based upon their demeanor, that claimant and his wife were not credible witnesses. She also found their testimony inconsistent. Based upon their demeanor at hearing, the Referee found claimant's co-worker and employer credible .

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). Consequently, we are persuaded that claimant's co-worker and employer are credible witnesses.

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, our agreement with the Referee's credibility finding concerning claimant and his wife is based upon their sworn testimony which was riddled with inconsistencies. Thus, we are persuaded that claimant and his wife are not credible.

To establish compensability claimant must prove that an industrial injury materially contributed to his disability and the need for medical attention. Hutcheson v. Weyerhaeuser, 288 Or 51 (1979); Summit v. Weyerhaeuser Company, 25 Or App 851,857 (1976). We conclude that claimant has failed to meet the requisite burden of proof.

The only evidence offered that lends support to claimant's contention that he suffered an on-the-job injury is the

report written by Dr. Anderson. Dr. Anderson opined that based upon the history provided by claimant it is possible that his symptoms were caused by his alleged industrial accident.

Yet, Dr. Anderson, based his opinion upon the information provided by claimant. This information was incorrect. Claimant stated that after his fall he laid at the bottom of the stairway for approximately 25 minutes and was found by his co-worker. His co-worker, however, stated that he did not see claimant fall, did not find claimant at the bottom of the stairway, did not see claimant show signs of injury and did not receive complaints from claimant about any injury or pain incurred during the workday. Because Dr. Anderson's opinion is based on incorrect information it is not persuasive. See Somers v. SAIF, 77 Or App 259, 263 (1986).

Claimant's wife testified that claimant was limping so badly on the day of his alleged accident that everyone would notice it. The employer testified that she did not see claimant limp when he and the co-worker returned to the office on the date of the alleged injury. This fact, when incorporated with the fact that claimant did not report an injury, is persuasive evidence that an injury did not occur.

Dr. Voiss reported that because claimant suffers organic brain damage and a history as an abused child, that he would attribute "internal feelings of pain" to a body part and events beyond his control.

These problems do not change claimant's burden of proof. For the reasons set forth herein, we conclude that claimant has failed to prove his claim compensable.

ORDER

The Referee's order dated November 24, 1987, as amended December 10, 1987, is affirmed.

JANET R. DANIELS, Claimant
Vick & Gutzler, Claimant's Attorneys
Liberty Northwest

WCB TP-88003
May 25, 1988
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 her cause of action for $7,500. The settlement is approved.

FINDINGS

The paying agency's lien currently totals $4,043.50. This sum consists entirely of bills for claimant's chiropractic treatments. She has neither received temporary nor permanent disability compensation.

The paying agency refuses to approve the settlement. On March 7, 1988, the agency was asked to respond to claimant's petition within 14 days. To date, no response has been forthcoming.

We find the present record sufficient to sustain judicial review.

CONCLUSIONS

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 appears to be grossly unreasonable. Kathryn I. Looney, 39 Van Natta 1140 (1987), Steven B. Lubitz, 39 Van Natta 809 (1987), Virginia Merrill, 35 Van Natta 251 (1983), Rose Hestkind, 35 Van Natta 250 (1983).

After reviewing this record and applying the aforementioned standards, we find the proposed settlement reasonable. Consequently, we approve the settlement offer of $7,500. Proceeds of the settlement shall be distributed in accordance with ORS 656.593(1).

IT IS SO ORDERED.

PAUL E. DILLMAN, Claimant
Peter O. Hansen, Claimant's Attorney
Norman Cole (SAIF), Defense Attorney
Waggoner, Farley, et al., Defense Attorneys
Acker, Underwood, et al., Defense Attorneys

WCB 87-08543, 86-14301 & 87-08542
May 25, 1988
Order Denying Motion to Dismiss

Liberty Northwest Insurance Corporation has moved the Board for an order dismissing claimant's request for Board review on the ground that a copy of the request was not served on all parties. We deny the motion.

FINDINGS

The Referee's order issued February 25, 1988. The parties to the hearing before the Referee included two employers and three insurers. One employer was insured by the SAIF Corporation. The other employer had been covered at separate intervals by SAIF and Liberty Northwest. SAIF retained outside counsel to represent this employer.

On March 10, 1988, the Board received claimant's March 9, 1988 request for review of the Referee's order. The request did not include an acknowledgment of service or a certificate of personal service by mail upon any of the parties who appeared at the hearing and their attorneys. See OAR 438-05-046(2)(b); 438-11-005(3). Neither Liberty Northwest nor its counsel received a copy of claimant's request for review.

On March 11, 1988, the Board mailed a computer-generated letter acknowledging the request. The acknowledgment was mailed to all the employers and their respective attorneys.

We find that the request was filed and that the parties received actual notice of the request within 30 days of the Referee's order.

CONCLUSIONS

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

"Party" means a claimant for compensation, the employer of the injured worker at the time of injury and the insurer, if any, of such employer. ORS 656.005(19). Attorneys are not included within the statutory definition of "party." Robert Casperson, 38 Van Natta 420, 421 (1986). Yet, in the absence of a showing of prejudice to a party, timely service of a request for Board review on the attorney for a party is adequate compliance with ORS 656.295(2) to vest jurisdiction in the Board. Argonaut Insurance v. King, supra, page 850-51; Nollen v. SAIF, 23 Or App 420, 423 (1975), rev den (1976); Robert C. Jaques, 39 Van Natta 299 (1987).

Here, claimant timely filed a request for Board review of the Referee's order. See ORS 656.289(3). However, he neglected to mail copies of the request for review to the parties. Thus, in order for the Board to retain jurisdiction, the parties must have received actual notice of the request within the statutory period. Argonaut Insurance Co. v. King, supra. We so find.

Since the Board's acknowledgment letter was mailed to both Liberty's insured and its counsel within 15 days after the Referee's order, we conclude that it is more probable than not they received actual notice of claimant's request for review within the statutory 30-day period. See John D. Francisco, 39 Van Natta 332 (1987); James L. Sampson, 37 Van Natta 1549, 1550 (1985). Furthermore, no contention has been made that Liberty Northwest has been prejudiced by not directly receiving a copy of claimant's request for review or the Board's acknowledgment. Absent such a finding, we hold that Liberty's insured's and counsel's timely actual notice of the request for review is adequate compliance with ORS 656.295(2) to vest jurisdiction in the Board. See ORS 656.295(2); Argonaut Insurance Co. v. King, supra, page 850-51; Nollen v. SAIF, supra.

Accordingly, Liberty Northwest's motion to dismiss is denied. Claimant's appellant's brief shall be due 14 days from the date of this order. The insurers' respondent's briefs shall be due 14 days from the date of mailing of claimant's brief. Claimant's reply, if any, shall be due 7 days after the date of mailing of the latest timely submitted respondent's brief. Thereafter, this case will be docketed for review.

IT IS SO ORDERED.

ARLO W. DUNBAR, Claimant
Bick & Monte, Claimant's Attorneys
SAIF Corp Legal, Defense Attorney

WCB TP-87017
May 25, 1988
Third Party Order on Reconsideration

Claimant moves for reconsideration of the Board's April 25, 1988 order that: (1) declined to grant claimant's request to direct the SAIF Corporation to execute a proposed settlement which would have disposed of two pending denied claims in return for the waiver of SAIF's third party lien; (2) found that claimant's current counsel's attorney fees were presently limited to his one-third share of the third party judgment; and (3) directed that the proceeds from the third party judgment be distributed in accordance with ORS 656.593(1).

The motion is granted and our April 25, 1988 order is withdrawn. On reconsideration, we adhere to and republish our April 25, 1988 order in its entirety, except that the parties' rights of appeal shall commence from the date of this order.

IT IS SO ORDERED.

LARRY R. GABBARD, Claimant
Malagon & Moore, Claimant's Attorneys
Foss, Whitty, et al., Defense Attorneys
Kate Donnelly (SAIF), Defense Attorney

WCB 87-07454 & 86-13512
May 25, 1988
Amended Order on Review

Reviewed by Board Members Ferris and Crider.

Claimant's counsel seeks Board authorization of an assessed fee for services rendered on review which culminated in our May 3, 1988 Order on Review.

After review of the statement of services and attorney retainer agreement submitted by claimant's counsel and considering the factors set forth in OAR 438-15-010(6), we approve an assessed fee of $450.

Accordingly, our May 3, 1988 order is abated and withdrawn. As amended herein, we adhere to and republish our May 3, 1988 order in its entirety. The parties' rights of appeal shall run from the date of this order.

IT IS SO ORDERED.

JEANETTE L. HERROD, Claimant
Doblie & Associates, Claimant's Attorneys
Edward C. Olson, Defense Attorney

WCB 87-08338
May 25, 1988
Order on Reconsideration

Claimant requests reconsideration of that portion of the Board's April 25, 1988 order that declined to award an assessed fee for her attorney's services on Board review.

After review of the statement of services and attorney retainer agreeement submitted by claimant's counsel and considering the factors set forth in OAR 438-15-010(6), we approve a reasonable assessed fee of $500.

Accordingly, our April 25, 1988 order is abated and withdrawn. On reconsideration, as supplemented herein, we adhere to and republish our April 25, 1988 order in its entirety. The parties' rights of appeal shall run from the date of this order.

IT IS SO ORDERED

MARK W. JEWELL, Claimant
Ralph W.G. Wyckoff, Claimant's Attorney
Roberts, et al., Defense Attorneys

WCB 87-02616
May 25, 1988
Order on Review

Reviewed by Board Members Ferris and Crider.

The insurer requests review of Referee Borchers' order that set aside its denial of claimant's elbow injury claim. We affirm.

ISSUE

The issue on review is compensability.

FINDINGS OF FACT

On January 22, 1987, claimant, 26 years old at the time of hearing, reported to the plant nurse that he hurt his elbow while working in the cannery.

Claimant's work activity consisted of repeatedly pushing and pulling a poker to remove corn coblettes from a cutter on a cannery belt line.

He first began to experience pain in his left elbow while removing coblettes from the cutter on January 21, 1987.

The plant nurse suggested claimant fill out an industrial accident report.

Claimant initially saw Dr. Peterson, M.D., who diagnosed bursitis and referred claimant to Dr. Strum, orthopedist. Strum became claimant's treating physician.

Claimant was examined by two more doctors.

The insurer issued its denial of claimant's elbow condition on February 9, 1987, stating that it did not arise out of and in the course and scope of employment.

Claimant's elbow condition was caused by his work activity.

CONCLUSIONS OF LAW AND OPINION

Claimant must prove by a preponderance of the evidence that his elbow injury arose out of and in the course and scope of his employment in order to establish compensability.

The insurer contends that claimant suffers a preexisting condition characterized by Dr. Strum as osteochonditis.

Dr. Strum initially considered the possibility that claimant's condition was preexisting osteochonditis. He ordered a bone scan in order to make a positive diagnosis. Upon receiving the results of the bone scan, Dr. Strum opined that claimant's symptoms were entirely related to his on-the-job activities rather than an osteochonditis condition. He also stated that the test confirmed that claimant's elbow condition was an acute process with no prior symptomology.

Dr. Jewell, M.D., reviewed Dr. Strum's notes and concluded that claimant had incurred an on-the-job injury. He opined that too much attention had been focused on the radiographic abnormalities of claimant's left elbow. Furthermore, he pointed out that claimant began to have similar symptoms in his opposite elbow when he was asked to do the declogging operations utilizing his right arm.

The medical evidence, as interpreted by the independent medical examiner as well as claimant's treating physician, showed that he suffered an acute trauma and had no prior symptomology. Dr. Strum, claimant's treating physician, stated that his left elbow condition was a direct result of the repetitive movement involved in declogging the belt line. Therefore, claimant has proved by a preponderance of the evidence that his work was a material contributing factor and causally related to his left elbow injury. Loehr v. liberty Nothwest Insurance Corp., 80 Or App 264 (1986). Consequently, we affirm the order of the Referee.

Claimant's counsel is statutorily entitled to a reasonable, carrier-paid attorney fee for services rendered on Board review. See ORS 656.382(2). Such a fee is defined as an "assessed fee." OAR 438-15-005(2). However, we cannot authorize an assessed fee unless claimant's counsel files a statement of services. See OAR 438-15-010(5). Because no statement of services has been received to date, an assessed fee shall not be authorized.

ORDER

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

THEODULE LEJEUNE, JR., Claimant
Pozzi, et al., Claimant's Attorneys
Roberts, et al., Defense Attorneys

WCB 86-12737
May 25, 1988
Second Amended Order of Dismissal

Claimant, pro se, has requested reconsideration of the Board's March 16, 1988 Amended Order of Dismissal. Pursuant to our order, the insurer's request for Board review was dismissed in accordance with the parties' disputed claim settlement. In addition, we approved the insurer's counsel's request to charge the insurer, a fee not to exceed $127.50 for legal services.

Claimant asks that his attorney-of-record be directed to pay him $250. Furthermore, he asserts that he has received only $5,000, whereas the settlement provides that he should receive $5,500. Consequently, he requests that the insurer be required to pay him the remaining $500. On April 14, 1988, our prior orders were abated and counsels for the parties were asked to respond to claimant's contentions. Having received their responses, we have reconsidered this matter and make the following findings and conclusions.

FINDINGS

On October 9, 1987, Referee Howell set aside the insurer's denial of claimant's injury claim for his current shoulder and back conditions. In addition, claimant's attorney was awarded a reasonable attorney fee of $1,500, to be paid by the insurer. The insurer timely requested Board review.

Thereafter, the parties submitted for our approval a proposed "Disputed Claim Settlement." Pursuant to the settlement, claimant agreed to the reinstatement of the insurer's denial of compensability. In return, claimant would accept $5,500. It was further agreed that claimant's attorney would be paid an attorney fee of $1,500, payable in addition to the settlement proceeds, and $500 in costs, which were payable out of the settlement proceeds. (Emphasis added).

On February 25, 1988, we approved the parties' disputed claim settlement and issued an order dismissing the insurer's request for Board review. On March 16, 1988, we amended our initial order to authorize the insurer's counsel to charge a fee to the insurer. (Emphasis added). Thereafter, claimant requested reconsideration, contending that his attorney had received too much money and that he had received only $5,000.

CONCLUSIONS

No release by a worker of any rights to workers' compensation benefits is valid. ORS 656.236(1). Notwithstanding ORS 656.236, in any case where there is a bona fide dispute over compensability of a claim, the parties may, with the approval of a Referee, the Board or the court, by agreement make such disposition of the claim as is considered reasonable. ORS 656.289(4). 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. OAR 438-15-050.

Here, the parties' settlement resolved a bona fide dispute over compensability of claimant's injury claim. Therefore, the aforementioned provisions are applicable.

Inasmuch as claimant's attorney's fee of $1,500 was payable in addition to, rather than out of, claimant's compensation, the total settlement proceeds were, in effect, $7,000. ($5,500 + $1,500). In accordance with the Board's attorney fee rules regarding disputed claim settlements, the maximum fee for such a settlement would be $1,750. Thus, claimant's attorney's fee was within the Board's attorney fee rules.

Moreover, we note that the fee was also less than the maximum recoverable under claimant's retainer agreement with his counsel, i.e., 25 percent of the first $8,000. Since claimant's attorney's fee was within the Board's rules, as well as his contractual limitations, we conclude that the fee was reasonable. Consequently, we decline to direct claimant's attorney to repay claimant $250.

We turn to claimant's contention that the insurer has withheld $500 from him, thereby failing to fully comply with the settlement. In full and final settlement of his claim, claimant agreed to accept $5,500. However, he further agreed that this sum would be reduced by $500 to reimburse his attorney for costs incurred during the litigation. Therefore, the total amount of

proceeds payable to claimant was $5,000, which was the amount he actually received. Because we find that claimant has received the amount to which he is entitled under the parties' settlement, we decline to direct the insurer to pay an additional $500.

Finally, we note that the reimbursement of the attorney's costs directly from the settlement's proceeds is not an invalid assignment of compensation. Since the settlement resolved the issue of compensability for claimant's injury claim, its proceeds were expressly agreed not to be compensation. Consequently, the assignment of a portion of these "noncompensation" proceeds would not be contrary to the provisions of ORS 656.234, which prohibits the assignment of compensation prior to its receipt by the entitled beneficiary.

Accordingly, the request for reconsideration is granted and our prior orders withdrawn. On reconsideration, as supplemented herein, we adhere to and republish our March 16, 1988 Amended Order of Dismissal. The parties' rights of appeal shall run from the date of this order.

IT IS SO ORDERED.

The Beneficiaries of
THOMAS McBROOM (Deceased), Claimant
Pozzi, Wilson, et al., Claimant's Attorneys
Roberts, et al., Defense Attorneys
Joseph D. Davis, Attorney

WCB TP-87029
May 25, 1988
Third Party Order

Claimant, Betty McBroom, as beneficiary of the estate of the deceased worker, has petitioned the Board to resolve a dispute concerning the proper distribution of the proceeds from a third party judgment. See ORS 656.593. Claimant contends that she is entitled to a share of the proceeds pursuant to ORS 656.593(1)(c). The paying agency responds that claimant elected not to proceed against the third party and, because claim costs exceed the remaining balance of the third party recovery, she is not entitled to a share of the proceeds from the judgment. See ORS 656.591.

FINDINGS

In May 1981 the deceased worker died while on a business trip in California. The claim was found to be compensable. See McBroom v. Chamber of Commerce of the U.S., 77 Or App 700 (1986). Within a year of the deceased worker's death, his widow, claimant, engaged a California attorney to institute a civil action for wrongful death against the hotel where her husband had died. Arrangements for claimant's California representation were made through her Oregon counsel. Thereafter, a complaint for wrongful death was filed in a California Superior Court.

In December 1983 the paying agency's counsel advised claimant's Oregon attorney that, if claimant elected not to pursue the third party action, the agency wished to proceed. In anticipation of claimant's decision, the agency requested an executed election form assigning claimant's cause of action to the agency.

In response, claimant's Oregon attorney reported that claimant was willing to sign the election form, provided that the agency reimbursed her for $575 in litigation costs. In February 1984 the paying agency agreed to provide reimbursement for

claimant's litigation costs. Thereafter, these costs were paid and copies of claimant's Oregon attorney's file were forwarded to the paying agency's counsel. However, an executed election form was not forthcoming.

In September 1984 claimant's California attorney requested permission to dismiss the third party action with prejudice. The request was directed to claimant's Oregon counsel, who forwarded it to the paying agency's attorney. In February 1985 the paying agency's counsel notified claimant's California attorney that claimant had authorized the paying agency to proceed with the action against the hotel. A copy of this notification was provided to claimant's Oregon attorney. Included with this copy was another request to claimant's Oregon attorney to forward an executed "third party election form."

When claimant's California attorney was reluctant to further pursue the case, the paying agency's counsel retained another California attorney to proceed against the hotel. Prior to this substitution, the hotel had been timely served with a copy of claimant's complaint.

In May 1985 the paying agency's counsel notified claimant's Oregon attorney of the substitution. Acknowledging claimant's Oregon attorney's prior assurances that claimant had signed an election form, the paying agency's counsel stated that a form had still not been received. Therefore, an executed form was again requested. The agency's counsel further noted that any proceeds received as a result of the action would be distributed pursuant to the third party statutes.

On his own behalf, claimant's Oregon attorney "approved" the May 1985 letter from the paying agency's counsel "in all respects." However, neither an executed election form nor an assignment were received from claimant. Shortly thereafter, the paying agency's counsel instructed the recently-appointed California attorney to proceed with the case. The agency's counsel noted that claimant "of course would, under Oregon law, be entitled to the proceeds after [the paying agency's] lien is paid."

In July 1985 the paying agency's counsel notified claimant that the paying agency was proceeding on her behalf against the hotel. Since a different California attorney had been retained, claimant was asked to sign a "Substitution of Attorney" form to be filed with the California court. Claimant signed the form, acknowledging the substitution of her California counsel. The form did not refer to an assignment of claimant's cause of action nor did it mention the paying agency in any manner.

In May 1987 the third party case proceeded to trial. Claimant was in attendance, and cooperated fully, during the nearly two week trial. Her travel expenses were covered by the paying agency. At no time was she asked to assign her cause of action against the hotel to the paying agency or anyone else. Furthermore, she was never advised that she would not receive a portion of the proceeds of the action, should it prove to be successful. Rather, it was her understanding that she would receive a portion of any recovery. Had she known that there was a possibility that she would not share in any recovery, claimant would not have willingly participated in the trial.

The third party judgment totalled $91,215. After deducting for attorney fees and litigation costs, a balance of $44,959.93 remains.

We find that claimant made no election not to recover damages from the third party. We further find that claimant did not assign her cause of action to the paying agency.

CONTENTIONS

The paying agency contends that claimant assigned her cause of action to the agency. Since the current and future claim costs exceed the remaining balance of the proceeds, the agency argues that claimant is not entitled to any portion of the third party judgment. See ORS 656.591(2).

Claimant asserts that she did not assign her cause of action to the paying agency. Since there was no assignment, she submits that she is entitled to her statutory 1/3 share of the remaining balance of the proceeds pursuant to ORS 656.593(1)(b).

CONCLUSIONS

If a worker receives a compensable injury due to the negligence or wrong of a third person not in the same employ, the worker shall elect whether to recover damages from such third person. ORS 656.578. The proceeds of any damages recovered from a third person by the worker shall be subject to a lien of the paying agency for its share of the proceeds. ORS 656.593.

When the worker or the beneficiaries elect to recover damages from the third party, the proceeds of any recovery shall be distributed as set forth in ORS 656.593(1). Costs and attorney fees incurred shall be initially disbursed. ORS 656.593(1)(a). Then, the worker or beneficiaries shall receive at least 33-1/3 percent of the balance of the recovery. ORS 656.593(1)(b). The paying agency shall be paid and retain the balance of the recovery to the extent that it is compensated for its expenditures for compensation, first aid or other medical, surgical or hospital service, and for the present value of its reasonably to be expected future expenditures for compensation and other costs of the worker's claim under ORS 656.001 to 656.794. ORS 656.593(1)(c). Any remaining balance shall be paid to the worker or beneficiaries. ORS 656.593(1)(d).

The paying agency may require the worker or other beneficiary or the legal representative of a deceased worker to exercise the right of election provided in ORS 656.578 by serving a written demand by registered or certified mail or by personal service upon such worker, beneficiaries or legal representative. ORS 656.583(1). Unless such election is made within 60 days from the receipt or service of such demand and unless, after making such election, an action against such third person is instituted within such time as is granted by the paying agency, the worker, beneficiaries or legal representative is deemed to have assigned the cause of action to the paying agency. ORS 656.583(2). The paying agency shall allow the worker, the beneficiaries, or legal representative of the worker at least 90 days from the making of such election to instititute such action. Id.

An election made pursuant to ORS 656.578 not to proceed against the employer or third person operates as an assignment to the paying agency of the cause of action, if any, of the worker, the beneficiaries or legal representative of the deceased worker, against the third person, and the paying agency may bring action against such third person in the name of the injured worker or other beneficiaries. ORS 656.591(1). The worker or other beneficiaries is entitled to any sum recovered by the paying agency in excess of the expenses incurred in making such recovery and the amount expended by the paying agency for compensation, first aid or other medical-related service, together with the present worth of future monthly payments of compensation. ORS 656.591(2).

Here, claimant elected to seek damages from the third party and instituted a cause of action for wrongful death. With this election, the provisions of ORS 656.583 (which compels an election to institute an action against the third party) and 656.591 (which applies to the distribution of proceeds where an election not to proceed against the third party has been made) became inoperable. Instead, upon claimant's election to recover damages from the third party, the distribution scheme contained in ORS 656.593(1) applied. These provisions allow for the worker's or the beneficiaries' one-third share from the remaining balance of the third party recovery. See ORS 656.593(1)(b).

The paying agency argues that claimant abandoned her cause of action and, thereby, elected not to proceed against the third party. The agency submits that this election effectively operated as an assignment of claimant's third party action. We disagree.

As previously discussed, ORS 656.583 and 656.591 contemplate elections at the initial stage of the proceedings, i.e., before a cause of action has been instituted. Here, claimant elected to proceed by instituting a cause of action against the third party. Even assuming that ORS 656.583 was applicable, the agency did not comply with the statute in that written demand to exercise the right of election was not served by registered or certified mail or by personal service upon claimant. Thus, claimant can not be "deemed to have assigned the cause of action to the paying agency." See ORS 656.583(1), (2).

Furthermore, by instituting the cause of action, claimant expressly elected to proceed against the third party. See ORS 656.591. Despite changes in representation and responsibility for litigation costs, claimant's ultimate objective remained constant, i.e., to recover damages from the third party. In other words, she never elected not to recover damages from the third party. See ORS 656.578. Inasmuch as claimant did not make an election pursuant to ORS 656.578 to not proceed against the third party, there has been no assignment of the cause of action to the paying agency. See ORS 656.591(1).

The parties have totally divergent views of this third party arrangement. The paying agency interprets claimant's conduct as an abandonment of her lawsuit and a complete assignment of her rights to any proceeds. On the other hand, claimant views the paying agency's involvement as an attempt to pursue, with her assistance, a potential source of reimbursement for its claim costs. Under this scenario, claimant would share in the proceeds, if any were eventually forthcoming.

Considering these diametrically opposed views, we are unable to conclude that claimant's conduct equates with the intentional and affirmative act occasioned by electing not to proceed against a third party. Moreover, the record would suggest otherwise. To begin, several of the paying agency's counsel's letters note that the agency was proceeding on claimant's behalf. This conclusion is further supported by the "Substitution of Attorneys" form filed with the California court that indicated the change in claimant's legal representation, with neither an assignment from claimant nor any reference to the paying agency.

In addition, neither claimant nor her California counsel were aware of the agency's position that claimant could likely not share in the third party proceeds. In fact, claimant would not have participated in the proceedings had she been aware that such a result was possible.

Finally, and most importantly, despite repeated requests from the paying agency to submit an executed election form, claimant never signed a document evidencing her knowing and intentional election not to pursue the third party action and to assign her action to the paying agency. In view of the significant impact such a decision would have on claimant's entitlement to share in the proceeds of any third party recovery, we consider a written election not to recover damages against the third party essential to operate as an assignment of a cause of action to the paying agency.

Having concluded that claimant did not assign her third party action to the paying agency, we find that she is entitled to her statutory 1/3 share of the proceeds of the judgment pursuant to ORS 656.593(1)(b). Accordingly, the paying agency is directed to forward to claimant 1/3 of the $44,959.93 remaining balance. The paying agency shall retain the remainder.

IT IS SO ORDERED.

MARIA C. MENDOZA, Claimant
Vick & Gutzler, Claimant's Attorneys
Emmons, et al., Attorneys
Kevin Mannix, Defense Attorney

WCB 88-01994
May 25, 1988
Order of Dismissal

Claimant has requested review of Referee Garaventa's Order Denying Reconsideration. We have reviewed the request to determine whether we have jurisdiction to consider the matter. We conclude that we lack jurisdiction.

FINDINGS

On April 1, 1988, the Referee issued an order dismissing claimant's request for hearing. On April 19, 1988, claimant requested reconsideration of the dismissal order, asking for reinstatement of her hearing request.

On May 4, 1988, the Referee issued an "Order Denying Reconsideration." After reviewing the case's procedural history, the Referee declined to grant claimant's request for rescission of the dismissal order.

On May 9, 1988, the Board received claimant's request for review of the Referee's May 4, 1988 order. The request

included a certificate of personal service by mail upon the other parties to the proceedings.

The Referee's April 1, 1988 dismissal order was neither abated, withdrawn, stayed, republished, modified, nor appealed within 30 days of its issuance.

CONCLUSIONS

A Referee's order is final unless, within 30 days after the date on which a copy of the order is mailed to the parties, one of the parties requests Board review under ORS 656.295. ORS 656.289(3). The time within which to appeal an order continues to run, unless the order has been "stayed," withdrawn, or modified. International Paper Co. v. Wright, 80 Or App 444 (1986); Fischer v. SAIF, 76 Or App 656, 659 (1986). In order to abate and allow reconsideration of an order issued under ORS 656.289(1), at the very least, the language of the second order must be specific. Farmers Insurance Group v. SAIF, 301 Or 612, 619 (1986).

Here, claimant has requested review of the Referee's May 4, 1988 order within 30 days of its issuance. Yet, the May 4, 1988 order issued more than 30 days after the April 1, 1988 dismissal order. Furthermore, the April 1, 1988 order was neither abated, withdrawn, stayed, modified, nor republished prior to the issuance of the May 4, 1988 order. Under these circumstances, we conclude that the Referee lacked jurisdiction to issue the May 4, 1988 order. ORS 656.289(3); International Paper Co. v. Wright, supra; Farmers Insurance Group v. SAIF, supra. Inasmuch as the May 4, 1988 order was issued without jurisdiction, it is a nullity. Thus, we lack jurisdiction to consider it.

The Referee had jurisdiction to issue the April 1, 1988 dismissal order. However, as discussed above, the 30-day statutory appeal period from that order has since elapsed unabated and without the timely filing of a request for Board review. Consequently, we also lack jurisdiction to review the April 1, 1988 order, which has become final by operation of law. See ORS 656.289(3); International Paper Co. v. Wright, supra; Farmers Insurance Group v. SAIF, supra.

Accordingly, the request for Board review is dismissed.

IT IS SO ORDERED.

PAULA M. MILLS, Claimant
Terrence J. Slominski, Claimant's Attorney
Rankin, VavRosky, et al., Defense Attorneys

WCB 87-06034
May 25, 1988
Order of Dismissal (Remanding)

Claimant has requested Board review of Referee Galloway's March 22, 1988 order. We have reviewed the request to determine whether we have jurisdiction to consider it. We conclude that jurisdiction rests with the Hearings Division.

FINDINGS

Claimant's request was filed on April 21, 1988. That same day, in response to claimant's motion for reconsideration, Referee Lipton issued an Order of Abatement.

CONCLUSIONS

Where simultaneous acts affect the vesting of jurisdiction in this forum, in the interest of administrative economy and substantial justice, we will give effect to the act that results in the resolution of the controversy at the lowest possible level. James D. Whitney, 37 Van Natta 1463 (1985).

Inasmuch as the Referee's March 22, 1988 order was abated 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. This matter is remanded to Referee Lipton for further action.

IT IS SO ORDERED.

PENNY L. NICKLE, Claimant
Francesconi & Associates, Claimant's Attorneys
Scheminske & Lyons, Defense Attorneys

WCB 87-09156
May 25, 1988
Order on Reconsideration

Claimant has submitted a statement of services and has requested reconsideration of the Board's Order on Review dated April 25, 1988. On reconsideration, claimant's attorney seeks Board authorization of an assessed fee for his services rendered on Board review.

The request is granted and the Board's prior order is withdrawn. On reconsideration, the Board adheres to and republishes its former order with the following supplementation, effective this date.

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. ORS 656.382(2); see also OAR 438-15-070.

In determining the reasonableness of an assessed fee, several factors must be considered. OAR 438-15-010(6). These factors include: (1) the time devoted to the case; (2) the complexity of the issue(s) presented; (3) the value of the interest involved; (4) the skill and standing of counsel; (5) the nature of the proceedings; (6) the results secured; (7) the risk that the attorney's efforts may go uncompensated; and (8) the assertion of frivolous issues or defenses.

Here, the sole issue on Board review was the extent of claimant's unscheduled permanent disability for her back condition. Claimant's Respondent's Brief was 11 pages in length. The result secured for claimant, was no reduction in the Referee's award of an additional 10 percent unscheduled permanent disability.

After considering the factors set forth in OAR 438-15-010(6), as they apply to this case, we conclude that claimant's attorney is entitled to a reasonable assessed fee of $750 for his services rendered on Board review.

IT IS SO ORDERED.

RONALD W. RIDINGS, Claimant
Malagon & Moore, Claimant's Attorneys
Gary Wallmark (SAIF), Defense Attorney

WCB 87-12190
May 25, 1988
Order on Review

Reviewed by Board Members Ferris and Crider.

Claimant requests review of Referee Howe's order that: (1) declined to award additional temporary disability compensation; and (2) declined to assess a penalty and associated attorney fee for the SAIF Corporation's alleged unreasonable termination of temporary disability compensation. We affirm.

ISSUES

1. Entitlement to additional temporary disability compensation.

2. Penalties and an associated attorney fee for alleged improper unilateral termination of temporary disability benefits.

FINDINGS OF FACT

Claimant, 47 years old as of the hearing, sustained an injury on January 31, 1985 when he slipped and fell while employed as an investigator for a district attorney's office. He suffered bruised elbows, a concussion and a cervical strain. The claim was accepted as a disabling injury.

Claimant had not returned to work as of February 22, 1985 when he was laid off from his job for reasons unrelated to his injury. In fact, claimant had anticipated the layoff prior to his injury and had arranged a new job as a truck driver. However, the injuries suffered in the January 1985 accident precluded him from commencing the truck driving job.

Claimant's then-treating physician subsequently diagnosed severe post-concussion syndrome and a severe depression resulting from the effect of his injuries. He referred claimant to Dr. Carter, psychiatrist. Claimant subsequently commenced treatment with Dr. Carter for his psychiatric problems and Dr. Wong for his physical injuries.

On April 20, 1987, Dr. Carter reported that a light-duty work release to investigatory work would be proper. On June 12, 1987, more than two years after commencing treatment of claimant, Dr. Carter concluded that claimant was not medically stationary but that he was "released for return to work without limitation." Dr. Carter indicated that he intended to follow claimant regularly over the next six months.

By chart note dated June 30, 1987, Dr. Wong opined that claimant could return to his previous occupation.

SAIF subsequently discontinued payment of temporary disability benefits.

Sometime after July 31, 1987, claimant was reemployed as an investigator at the district attorney's office. His new employment duties differed somewhat from those of his prior position. Approximately ten days later, he was laid off, again for reasons unrelated to his compensable injury.

On September 22, 1987, Dr. Carter reported that claimant had not reached a medically stationary stage and that return to his former job would "be an occurrence of specific therapeutic value in order to achieve becoming medically stationary."

CONCLUSIONS OF LAW AND OPINION

Relying upon the Court of Appeals' decision in Jackson v. SAIF, 7 Or App 109 (1971), the Referee concluded that SAIF was entitled to unilaterally terminate temporary benefits when claimant returned to regular work, was released to return to regular work, or there was a determination that claimant was medically stationary. The Referee found that claimant's treating physicians -- Dr. Carter and Dr. Wong -- had released claimant to return to regular work by June 12, 1987. The Referee, therefore, held that SAIF was authorized to terminate temporary benefits as of that date.

Claimant argues on review that reliance upon prior cases, including presumably Jackson v. SAIF, is inappropriate in view of the 1987 amendments to the Workers' Compensation statutes. After reviewing claimant's arguments, we are not persuaded that the 1987 revisions support claimant's position. Moreover, we note that the revisions cited by claimant are not effective until January 1, 1988 and, therefore, are not applicable to this 1985 injury claim. See Fromme v. Fred Meyer, Inc., 89 Or App 397 (1988).

Claimant argues that SAIF's conduct in terminating temporary disability benefits amounts to an attempted "partial" closure of his claim. Claimant asserts that if carriers wish to have "partial" closure rights, they should seek legislative relief. Claimant contends that, in the absence of such relief, a unilateral suspension of temporary benefits is only appropriate where claimant has become medically stationary and/or has returned to regular work. It is undisputed that claimant here was not medically stationary nor had he returned to his regular work. See Georgia Pacific v. Awmiller, 64 Or App 56, 60 (1983) (where the court held return to the workers' "regular" employment meant return to the job held at the time of the injury).

Since Jackson v. SAIF, the Court of Appeals has reiterated that one of the situations under which temporary benefits may be unilaterally terminated by the insurer is when claimant has been released by his treating doctor to return to his regular work. See Bold v. SAIF, 60 Or App 392 (1982); Emery v. Adjustco, 82 Or App 101 (1986). Support for this position can be found in former ORS 656.268(2) (now renumbered ORS 656.268(2)(c)), which states, in pertinent part:

> "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."

Claimant attempts to distinguish Jackson, Emery and Bold on factual grounds. We agree that the cases are not directly on

point factually, but we cannot accept claimant's argument that these distinctions permit us to ignore the court's unequivocal statements to the effect that a treating physician's release to regular work permits unilateral termination of temporary benefits.

With regard to Bold, supra, claimant contends that the case supports the proposition that a release to regular work "on a trial basis" does not terminate a worker's entitlement to temporary disability. We addressed the issue of a trial release to regular work in our Board order in Bold, where we stated: "We are familiar with the situation in which a physician is unsure whether a worker can return to work and releases the worker on a trial basis. In such cases, if the worker is unable to handle the employment, entitlement to time loss resumes." Berlie O. Bold, 34 Van Natta 244, 245, aff'd 60 Or App 392 (1982).

Relying upon this language, SAIF argues that a worker who has been released to regular work on a "trial basis" is entitled to a resumption of time loss only if he or she later proves unable to handle the employment. We decline to interpret our decision in Bold so narrowly. We expressly noted in Bold that there was no evidence that claimant was released on a trial basis. Thus, our discussion regarding the effect of the worker's inability to handle the employment in a trial-release context was dicta. Furthermore, while the Court of Appeals affirmed our decision in Bold, it did so on grounds other than that advanced in our opinion.

Subsequent to our decision in Bold, we held in Wayne A. Volk, 36 Van Natta 1083, 1084 (1984), that a trial release does not terminate the duty to pay time loss. In Volk, two physicians released claimant to return to regular work. SAIF subsequently discontinued payment of temporary benefits. We found that the releases were on a trial basis. We held that SAIF had a duty to continue paying time loss until a Determination Order issued, until claimant actually returned to full time regular work or until he obtained a full release. We also held that penalties were not warranted as SAIF had not acted unreasonably. The Court of Appeals reversed on the penalty issue only. Volk v. SAIF, 73 Or App 643 (1985).

We conclude that a worker's release to return to work on a "trial basis" does not extinguish his entitlement to temporary disability benefits. Instead, the amount of benefits is subject to reduction for wages actually earned. See Donald W. Courtier, 39 Van Natta 705, 708 (1987).

It remains for us to determine whether claimant has been released by his "attending physician" to return to work on a trial basis. We note preliminarily that an injured worker can have only one attending physician. OAR 436-10-060(2). We find that Dr. Carter is claimant's attending physician within the meaning of ORS 656.005(13).

On June 12, 1987, Dr. Carter signed a job analysis form indicating that claimant was approved for release to employment as a special investigator for the district attorney's office. This was his regular employment. On the same day, Dr. Carter sent a letter to claimant's vocational counselor stating that he was releasing claimant "for return to work without limitations." In the same letter, Dr. Carter indicated that claimant was not medically stationary and that he intended to follow claimant

regularly over the next six months. Whether this release constitutes a "trial release" is a close question. We conclude, however, that Dr. Carter's work release was to full, regular employment on a nontrial basis. See Debra A. Reese, 38 Van Natta 101 (1986).

Therefore, SAIF did not improperly terminate claimant's temporary disability benefits. Consequently, it follows that its denial was not unreasonable.

ORDER

The Referee's Order on Reconsideration dated November 27, 1987, as further reconsidered on December 23, 1987, is affirmed.

DWANE WATTS, Claimant
Samuel A. Hall, Claimant's Attorney
Cowling & Heysell, Defense Attorneys

WCB 85-14239
May 25, 1988
Order on Review

Reviewed by Board Members Crider and Johnson.

Claimant, pro se, requests review of Referee Holtan's order that: (1) upheld the insurer's denial of his occupational disease claim for bronchospasm and asthma; (2) upheld the insurer's denial of his occupational disease claim for coronary atherosclerotic disease; (3) declined to assess a penalty and attorney fees for alleged unreasonable denials of both claims; and (4) declined to assess a penalty and associated attorney fee for alleged untimely denial of the coronary atherosclerotic disease claim. With his brief, claimant has submitted documents and testamentary evidence not previously admitted at hearing. We treat these submissions as a request for remand to the Referee for further evidence taking. We reject the request to remand and, on the merits, affirm.

ISSUES

1. Compensability of claimant's claim for chest pains and asthma.

2. Compensability of claimant's claim for coronary atherosclerotic disease.

3. Penalties and attorney fees for unreasonable denial.

4. Penalties and attorney fees for untimely denial.

FINDINGS OF FACT

We adopt the Referee's findings of fact, denominated "Background Facts" in his opinion, with the following supplementation.

Claimant smoked, on average, one to two packs of cigarettes per day for the prior 20 or more years. He suffered from hypertension approximately 10 years prior to the events in question.

Claimant's work environment was often dusty. He did not use a respirator while working. The employer was subsequently cited for failure to provide adequate respiratory protection.

There was no evidence, however, that dust levels or chemical content of the dust exceeded allowable state or federal safety limits.

Claimant's work exposure was not the major contributing cause of his chest pains and asthma nor his coronary atherosclerotic disease.

CONCLUSIONS OF LAW AND OPINION

Additional Evidence

With regard to the additional evidence proferred by claimant, 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). We find that the additional evidence is not material. Claimant's request for remand is denied.

Compensability, Penalties and Attorney Fees

We affirm and adopt the Referee's opinion on the merits.

ORDER

The Referee's order dated June 5, 1987 is affirmed and adopted. A client-paid fee not to exceed $833 is approved.

ARBRA WILLIAMS, Claimant
Bloom, et al., Claimant's Attorneys
Raymond Smitke (SAIF), Defense Attorney

WCB 86-05202
May 25, 1988
Order of Dismissal

Claimant moves the Board for an order dismissing SAIF Corporation's request for Board review on the ground that the Board is without jurisdiction to address the issue raised in SAIF's request. The motion is granted.

ISSUE

Whether the Board has jurisdiction to address the issue of the amount of an attorney fee awarded by the Referee under ORS 656.386(1).

FINDINGS OF FACT

Claimant compensably injured his low back on August 11, 1982. The claim was closed by Determination Order dated October 18, 1985. Claimant subsequently requested a hearing and raised a variety of issues including premature closure and a partial denial of a psychological condition allegedly related to the compensable low back injury. At the hearing, SAIF agreed to accept claimant's psychological condition. The attorney fee on the denial, however, was left for the Referee's decision.

In his order, the Referee set aside the October 1985 Determination Order as premature and ordered SAIF to pay claimant's attorney a fee of $4,598 in connection with the partial denial of the psychological condition. SAIF timely filed a request for Board review. The request for Board review was nonspecific, but SAIF's appellant's brief expressly waived review of all issues except the amount of the attorney fee awarded by the Referee in connection with the psychological denial.

OPINION AND CONCLUSIONS

In Greenslitt v. City of Lake Oswego, 305 Or 530, 533-34 (April 26, 1988), the Court ruled that when a claimant prevails before a referee on the denial of a claim for compensation and the Referee awards the claimant's attorney a fee under ORS 656.386(1), the Board is without jurisdiction to entertain an appeal regarding the amount of the fee if the denial was not also appealed on the merits. Review of the attorney fee in such cases must instead be sought in the appropriate circuit court under ORS 656.388(2). Id. at 534.

The Referee in the present case awarded claimant's attorney a carrier-paid fee in connection with SAIF's denial of claimant's psychological condition. The Referee cited no authority for his action, but the only authority for such a fee would be ORS 656.386(1). SAIF sought Board review only on the issue of the amount of the attorney fee awarded by the Referee. Under these circumstances, Greenslitt would appear to mandate dismissal of SAIF's request for review.

SAIF argues that the Board should deny claimant's motion to dismiss on the ground that claimant's original injury occurred before the 1983 amendment to ORS 656.386(1) which made the circuit court proceeding mandatory. See Or Laws 1983, ch 568, § 2; Greenslitt v. City of Lake Oswego, 88 Or App 94, 100 (1987), aff'd, 305 Or 530 (1988); SAIF v. Anlauf, 52 Or App 115, 119 (1981). In support of this argument, SAIF cites ORS 656.202(2), which states:

> "Except as otherwise provided by law, payment of benefits under ORS 656.001 to ORS 656.794 shall be continued as authorized, and in the amounts provided for, by the law in force at the time the injury giving rise to the right to compensation occurred."

We reject SAIF's argument. Attorney fees are not "benefits" or "compensation" within the meaning of the Workers' Compensation Law. Dotson v. Bohemia, Inc., 80 Or App 233, 236, rev den 302 Or 35 (1986). Consequently, ORS 656.202(2) does not require application of the former version of ORS 656.386(1) and, under Greenslitt, SAIF's request for Board review must be dismissed.

IT IS SO ORDERED.

RUTH B. McMILLAN, Claimant
Bischoff & Strooband, Claimant's Attorneys
Roberts, et al., Defense Attorneys

Own Motion 88-0233M
May 27, 1988
Own Motion Order

The insurer has submitted to the Board claimant's claim for an alleged worsening of her July 26, 1977 industrial injury. Claimant's aggravation rights have expired. The insurer opposes reopening as it contends claimant's condition did not materially worsen in August 1986 and that any need for benefits occurred almost two years ago.

Pursuant to ORS 656.278(1)(a), we may exercise our "Own Motion" authority when we find that there is a worsening of a compensable injury that requires either inpatient or outpatient surgery or other treatment requiring hospitalization. In such cases, we are authorized to award temporary disability compensation commencing from the time the worker is actually hospitalized or undergoes outpatient surgery.

The medical evidence is clear that claimant's compensable condition temporarily worsened requiring hospitalization for therapy, bed rest, traction and diagnostic testing. We conclude the claim does qualify for reopening under ORS 656.278. Accordingly, claimant's claim is reopened with temporary total disability compensation to commence August 27, 1986 and to continue until claimant returns to her regular work at her regular wage or is medically stationary, whichever is earlier. Claimant's attorney is awarded 25% of the additional compensation granted by this order, not to exceed $300 as a reasonable attorney's fee. Reimbursement from the Reopened Claims Reserve is authorized to the extent allowed under ORS 656.625 and OAR 436, Division 45. When appropriate, the claim shall be closed by the insurer pursuant to OAR 438-12-055.

IT IS SO ORDERED.

VERNON PRIDDY, Claimant
SAIF Corp, Insurance Carrier

Own Motion 88-0258M
May 27, 1988
Own Motion Order

SAIF Corporation has submitted to the Board claimant's claim for an alleged worsening of his April 7, 1981 industrial injury. Claimant's aggravation rights have expired. SAIF opposes reopening of this claim for the payment of temporary total disability as it contends claimant's flare-up in September 1987 did not represent a material worsening of his condition and also that claimant has removed himself from the work force.

Although claimant had not worked for a few months prior to the September 1987 flare-up, we are not persuaded that he has voluntarily removed himself from the work force on a permanent basis. However, pursuant to ORS 656.278(1)(a), we may exercise our "Own Motion" authority only when we find that there is a worsening of a compensable injury that requires either inpatient or outpatient surgery or other treatment requiring hospitalization. In such cases, we are authorized to award temporary disability compensation commencing from the time the worker is actually hospitalized or undergoes outpatient surgery.

Claimant's brief flare-up in September 1987 did not require hospitalization for treatment or surgery. We conclude we

are without authority to grant the relief claimant seeks. The request for own motion relief is hereby denied.

IT IS SO ORDERED.

CHARLES TALLARD, Claimant
Vick & Gutzler, Claimant's Attorneys
Beers, et al., Defense Attorneys

Own Motion 88-0249M
May 27, 1988
Own Motion Order

The insurer has submitted to the Board claimant's claim for an alleged worsening of his February 10, 1981 industrial injury. Claimant's aggravation rights have expired. The insurer opposes reopening of this claim as claimant's condition remains medically stationary and there is no hospitalization or surgery recommended at this time.

Pursuant to ORS 656.278(1)(a), we may exercise our "Own Motion" authority when we find that there is a worsening of a compensable injury that requires either inpatient or outpatient surgery or other treatment requiring hospitalization. In such cases, we are authorized to award temporary disability compensation commencing from the time the worker is actually hospitalized or undergoes outpatient surgery.

The medical evidence indicates that claimant continues under the care of Dr. Close, a chiropractor. Although pain center treatment was considered, there is no evidence that claimant plans to enroll in a program. We find there is no recommendation for surgery, either inpatient or outpatient, and no need for hospitalization for treatment. Therefore, we conclude we have no authority to reopen this claim for the payment of further temporary disability benefits. ORS 656.278. The request for own motion relief is hereby denied.

IT IS SO ORDERED.

FORREST BELL, Claimant
Industrial Indemnity, Insurance Carrier
Liberty Northwest, Insurance Carrier

Own Motion 88-0320M
June 1, 1988
Consent to Issuance of Order Designating a Paying Agent (ORS 656.307)

The Compliance Division has notified the Board that it is prepared to issue an order designating a paying agent under ORS 656.307 and OAR 436-60-180. Each of the employers/insurers have provided their written acknowledgment that the only issue is responsibility for claimant's otherwise compensable claim. Claimant's aggravation rights under his claims with Oregon Steel Mills and Industrial Indemnity have expired. Thus, those claims are subject to ORS 656.278.

Pursuant to OAR 438-12-032(3), the Board shall notify the Compliance Division that it consents to the order designating a paying agent, if it finds that the claimant would be entitled to own motion relief if an own motion insurer is the party responsible for payment of compensation. The Board may exercise its own motion jurisdiction if there is a worsening of a compensable injury that requires either inpatient or outpatient surgery or other treatment requiring hospitalization. ORS 656.278(1)(a). In such cases, the

Board may authorize the payment of temporary disability compensation from the time the worker is actually hospitalized or undergoes outpatient surgery until the worker's condition becomes medically stationary, as determined by the Board. id.

The record establishes that there has been a worsening of claimant's compensable injury requiring either inpatient or outpatient surgery or other treatment requiring hospitalization. Inasmuch as claimant would be entitled to own motion relief if an own motion insurer is found responsible for claimant's current condition, the Board consents to the order designating a paying agent. Furthermore, for the purposes of ORS 656.625 and OAR 436, Division 45, this consent constitutes an order reopening a claim under ORS 656.278 and the Board's rules if the designated paying agent is an own motion insurer. See OAR 438-12-032(3).

LUANN M. BREEDEN, Claimant
Charles D. Maier, Claimant's Attorney
Schwabe, et al., Defense Attorneys

WCB 87-09362
June 2, 1988
Order on Reconsideration

Claimant and the self-insured employer have each requested reconsideration of the Board's Order on Review dated May 3, 1988, which affirmed the Referee's finding that claimant had sustained a compensable low back injury. In our Order on Review, we declined to grant either claimant's attorney or the employer's attorney an attorney fee for their services on review because neither had submitted a statement of services. Attached to each request for reconsideration is a statement of services. Claimant's attorney seeks an assessed fee and the employer's attorney a client-paid fee.

Our May 3, 1988 order is abated and withdrawn. On reconsideration, we adhere to and republish our Order on Review with the following supplementation.

Claimant's attorney is awarded an assessed fee of $850, to be paid by the self-insured employer. The Board approves a client-paid fee not to exceed $1,053.

IT IS SO ORDERED.

DAVE WENDELL CORBIN, Claimant
SAIF Corp, Insurance Carrier

Own Motion 88-0052M
June 2, 1988
Own Motion Order

SAIF Corporation has submitted to the Board claimant's claim for an alleged worsening of his May 31, 1967 industrial injury. Claimant's aggravation rights have expired. SAIF opposes reopening of this claim as claimant has been unable to show any loss of earnings. There is also a dispute over payment of the medical bills.

Claimant has requested authorization from SAIF for implant surgery of the left eye. SAIF contends it will not have to pay for the procedure if it is done at the Veterans' Administration Hospital. Claimant's disagrees with SAIF's position. To date, this dispute has not been resolved.

The Board concludes that, until the recommended surgery has been authorized by SAIF, the request for own motion relief is premature. SAIF's responsibility for claimant's surgery is a

claim for compensation under ORS 656.245 and must be accepted or rejected in accordance with ORS Chapter 656. If denied, the proper forum to resolve the dispute is the Hearings Division of the Board, if a timely appeal from the denial is made. The request for own motion relief is denied at this time as premature. Should SAIF ultimately be found responsible for the implant surgery, claimant can again seek own motion relief.

IT IS SO ORDERED.

TIMOTHY H. CRUCHELOW, Claimant
Paul S. Bovarnick, Claimant's Attorney
Schwabe, et al., Defense Attorneys

WCB 86-06981 & 86-06982
June 2, 1988
Amended Order on Review

Reviewed by Board Members Johnson and Crider.

The insurer's counsel seeks Board authorization of a client-paid fee for services rendered on review which culminated in our May 3, 1988 Order on Review.

After reviewing the statement of services and attorney retainer agreement submitted by the insurer's counsel and considering the factors set forth in OAR 438-15-010(6), we approve a client-paid fee, not to exceed $1,068.

Accordingly, our May 3, 1988 order is abated and withdrawn. As amended herein, we adhere to and republish our May 3, 1988 order in its entirety. The parties' rights of appeal shall run from the date of this order.

IT IS SO ORDERED.

RALPH H. GARRELTS, Claimant
Roberts, et al., Defense Attorneys

WCB 87-17585
June 2, 1988
Order Denying Motion to Dismiss

The insurer has moved for an order dismissing claimant's request for Board review on the ground that a copy of the request was not served on all parties. We deny the motion.

FINDINGS

The Referee's Order of Dismissal issued February 11, 1988. On February 22, 1988, via certified mail, claimant requested Board review of the Referee's order.

The request for review did not include an acknowledgment of service or a certificate of personal service by mail upon any of the parties who appeared at the hearing and their attorneys. See OAR 438-05-046(2)(b); 438-11-005(3). However, the request for review indicated that a copy of the request had been provided to the employer and its insurer. In addition, copies of certified mail receipts, which have been submitted in response to the insurer's motion, indicate that correspondence from claimant was received by the employer on February 23, 1988, and by the insurer on February 25, 1988.

On February 25, 1988, the employer acknowledged receipt of claimant's request and noted that the matter was being referred to its insurer. Neither the insurer nor its counsel have a copy of the request for review in their respective files.

We find that the request was filed and copies of the request were mailed to the parties within 30 days of the Referee's order.

CONCLUSIONS

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

"Party" means a claimant for compensation, the employer of the injured worker at the time of injury and the insurer, if any, of such employer. ORS 656.005(19). Attorneys are not included within the statutory definition of "party." Robert Casperson, 38 Van Natta 420, 421 (1986).

Here, claimant timely filed a request for Board review of the Referee's order. See ORS 656.289(3). Furthermore, included with his request, was his representation that copies had been provided to the employer and the insurer. This representation is supported by the documents submitted by claimant in response to the insurer's motion to dismiss. These materials indicate that both the employer and the insurer received correspondence from claimant shortly after he filed his request for review. Moreover, these materials suggest that the information received by the employer was promptly referred to the insurer.

Under these circumstances, we find that claimant timely mailed a copy of his request for Board review to all parties to the proceeding. See ORS 656.295(2); Argonaut Insurance Co. v. King, supra. Assuming for the sake of argument that the insurer did not timely receive notice of the request for review, no contention has been made that it has been prejudiced. Absent such a finding, we hold that the employer's timely notice of the request for review is adequate compliance with ORS 656.295(2) to vest jurisdiction in the Board. See ORS 656.295(2); Argonaut Insurance Co. v. King, supra, page 850-51; Nollen v. SAIF, 23 Or App 420, 423 (1975), rev den (1976).

For the foregoing reasons, we conclude that we have jurisdiction to consider claimant's request for review. Accordingly, the motion to dismiss is denied.

As a result of our consideration of this motion, it will be necessary to amend the briefing schedule. Therefore, the insurer's respondent's brief shall be due 14 days from the date of this order. Claimant's reply brief, if any, shall be due 14 days from the date of mailing of the insurer's brief. Thereafter, this case will be docketed for Board review.

IT IS SO ORDERED.

GILBERT T. HALE, Claimant
David Force, Claimant's Attorney
Garrett, et al., Defense Attorneys

WCB 85-12110 & 86-15750
June 2, 1988
Order on Review

Reviewed by Board Members Crider and Ferris.

Claimant requests review of Referee Brown's order which: (1) declined to award him permanent total disability; and (2) affirmed the Determination Orders that awarded him 20 percent (64 degrees) unscheduled permanent disability for a left shoulder injury and 10 percent (15 degrees) scheduled permanent disability for the loss of use or function of the left forearm. The issues are permanent total disability and, potentially, extent of permanent disability, scheduled and unscheduled.

We affirm the order of the Referee.

FINDINGS OF FACT

Claimant, a dry-belt grader, compensably injured his left shoulder on August 18, 1979, when he fell into a pit. The diagnosis was a rotator cuff tear. Claimant continued to work for the employer until October 1983, when his employment was terminated for reasons unrelated to his industrial injury. A dispute, unrelated to the injury, subsequently arose between claimant and the employer concerning the termination of employment. That dispute was settled by agreement, wherein claimant waived any right to reinstatement to employment. Claimant later worked for a short time as a busboy and has not worked since then.

In May 1986, claimant underwent surgery to repair the rotator cuff tear. He became medically stationary on August 22, 1986. The injury claim was closed by Determination Order on November 3, 1986 with 20 percent unscheduled permanent disability.

There is insufficient evidence to support a finding that claimant is totally incapacitated, from a physical standpoint. In addition, the evidence is insufficient to establish that claimant is permanently disabled due to a combination of his physical condition and nonmedical conditions.

CONCLUSIONS AND OPINION

The Referee declined to award claimant permanent and total disability and, instead, affirmed the Determination Order award of 20 percent unscheduled permanent disability for the shoulder injury and 10 percent scheduled permanent disability for the loss of use or function of the left forearm. We agree with the Referee's decision.

To prove his entitlement to permanent total disability, claimant must establish that he is unable to perform any work at a gainful and suitable occupation. ORS 656.206(1)(a); Wilson v. Weyerhaeuser, 30 Or App 403, 408-09 (1977). Claimant is clearly not totally incapacitated on a physical or medical basis. He is capable of performing some work. Consequently, claimant can prevail only by proving that he falls within the so-called "odd-lot" doctrine. Under that doctrine, a disabled person, capable of performing work of some kind, may still be permanently and totally disabled due to a combination of his physical condition and certain nonmedical factors, such as age, education,

work experience, adaptability to nonphysical labor, mental capacity and emotional conditions. Clark v. Boise Cascade Corp., 72 Or App 397, 399 (1985).

Here, claimant has prior work experience in sales. Indeed, he owned and operated his own sales business. He testified that he could return to sales work so long as he liked the product he was selling. With regard to claimant's functional capacity, we are persuaded by his treating physician's November 17, 1986 chart note that claimant had performed some overhead work and heavy/medium work, i.e., splitting firewood. Although claimant's credible testimony differed from the chart note, we find the note more reliable. Given the foregoing findings, as well as claimant's age and high school education, we are unable to conclude that claimant is permanently and totally disabled under the "odd-lot" doctrine. We conclude, therefore, that claimant is not entitled to an award of permanent total disability.

The criterion for rating unscheduled permanent disability is the permanent loss of earning capacity due to the compensable injury. ORS 656.214(5). In determining the loss of earning capacity, we consider medical and lay evidence of physical impairment resulting from the compensable injury and all of the relevant social and vocational factors set forth in OAR 436-30-380 et seq. We apply these rules as guidelines, not as restrictive mechanical formulas. Harwell v. Argonaut Insurance Co., 296 Or 505, 510 (1984); Fraijo v. Fred N. Bay News Co., 59 Or App 260, 269 (1982).

Dr. Schachner, the physician treating claimant for the shoulder injury, rated his impairment as mildly moderate. There was no other conflicting medical evidence. Although claimant's testimony differed in some respects, we found the medical evidence most persuasive. We find, therefore, that claimant's impairment is mildly moderate. Claimant's age further impacts his earning capacity; however, the impact is mitigated by his promising labor market potential. After considering these factors, we conclude that a 20 percent (64 degrees) unscheduled disability award adequately compensates claimant for his left shoulder injury.

The criterion for rating scheduled permanent disability is the permanent loss of use or function of the affected member due to the compensable condition. ORS 656.214(2). Here, Dr. Tearse, claimant's treating neurologist, opined in December 1985 that claimant had a mild disability due to the carpal tunnel condition. At that time, claimant was experiencing mild sensory loss in the left fingers. Dr. Tearse subsequently opined in March 1986 that the condition had apparently resolved. However, at the time of hearing, claimant complained of some loss of use in the left forearm.

We are persuaded that claimant's use of the left forearm is permanently impaired. Based primarily on claimant's lay testimony, we rate the impairment as mild and conclude that he is adequately compensated by a 10 percent (15 degrees) scheduled disability award for the loss of use or function of the left forearm.

ORDER

The Referee's order dated June 15, 1987 is affirmed.

JULIE E. JOHNSON, Claimant
Merrill Schneider, Claimant's Attorney
Schwabe, et al., Defense Attorneys

WCB 87-13332
June 2, 1988
Amended Order on Review

The self-insured employer has requested reconsideration of the Board's Order on Review dated May 3, 1988, which affirmed the Referee's decision declining to assess a penalty or attorney fee against the employer for its late payment of a Board ordered insurer paid fee. In our Order on Review, we did not grant the employer's attorney a client paid fee for services on review because he had not submitted a statement of services. OAR 438-15-010(5). The employer's request for reconsideration attaches a statement of services and seeks an award of a client-paid fee for its attorney's services on review.

We withdraw our May 3, 1988 order for reconsideration. On reconsideration, we adhere to and republish our Order on Review with the following amendment.

BACKGROUND

The present case came about as a result of the employer's failure to timely pay a Board ordered insurer-paid fee to claimant's attorney. In an enforcement proceeding, Referee Menashe declined to assess a penalty or attorney fee against the employer. We affirmed.

ISSUE

Whether the employer's attorney's request for a $2,474 client-paid fee is reasonable.

FINDINGS OF FACT

On review, the facts are stipulated and the sole issue is penalties and attorney fees.

The employer submitted a 3-1/2 page Respondent's Brief, of which the first 1-1/2 pages recited the stipulated facts.

The employer's statement of services requests Board authorization of a $2,474 client paid fee for 28.75 hours of time.

The employer's statement of services appears to include time devoted to issues previously litigated but not before the Board in the instant case.

CONCLUSIONS OF LAW

The Board shall authorize a client-paid fee that is reasonable. OAR 438-15-020(2). A determination of whether a client-paid fee is reasonable, shall include consideration of the following factors: (1) the time devoted to the case; (2) the complexity of the issues(s) involved; (3) the value of the interest involved; (4) the skill and standing of the attorneys; (5) the nature of the proceedings; (6) the result secured for the represented party: (7) the risk in a particular case that an attorney's efforts may go uncompensated; and (8) the assertion of frivolous issues or defenses.

Here, the time devoted to the present case is not accurately reflected in the employer's attorney's statement of services. The statement of services includes time devoted to

issues which are not presently before us. Second, the sole issue presently on review is relatively straight forward; i.e., whether claimant's attorney is entitled to a penalty or attorney fee for the employer's late payment of a Board ordered insurer-paid fee. Third, the nature of the proceedings have been straight forward and not complex in that the parties stipulated to the facts prior to the hearing.

Under such circumstances, in light of OAR 438-15-010(6), we approve a client-paid fee not to exceed $700.

IT IS SO ORDERED.

RICHARD A. LUNA, Claimant
Black, Chapman & Webber, Claimant's Attorneys
Schwabe, et al., Defense Attorneys

WCB 87-03680
June 2, 1988
Amended Order on Review

Reviewed by Board Members Ferris and Crider.

The self-insured employer's counsel seeks Board authorization of a client-paid fee for services rendered on review which culminated in our May 5, 1988 Order on Review.

After reviewing the statement of services and attorney retainer agreement submitted by the employer's counsel and considering the factors set forth in OAR 438-15-010(6), we approve a client-paid fee, not to exceed $966.

Accordingly, our May 5, 1988 order is abated and withdrawn. As amended herein, we adhere to and republish our May 5, 1988 order in its entirety. The parties' rights of appeal shall run from the date of this order.

IT IS SO ORDERED.

MICHAEL K. McRORIE, Claimant
Emmons, et al., Claimant's Attorneys
Merrily McCabe (SAIF), Defense Attorney

WCB 86-09646
June 2, 1988
Order on Review

Reviewed by Board Members Ferris and Crider.

Claimant requests review of Referee Hettle's order that declined to award additional scheduled permanent disability for a left leg condition, beyond a prior award of 10 percent (15 degrees) awarded by two Determination Orders.

The Board affirms and adopts the Referee's order with the following supplementation.

ISSUE

The extent of claimant's scheduled permanent disability for loss of use or function of his left leg.

FINDINGS OF FACT

Claimant compensably injured his left knee in October 1985. Thereafter, he began to treat with Dr. Stanley, orthopedist.

A Determination Order closed claimant's claim in July 1986, awarding 5 percent scheduled permanent disability. Shortly thereafter, he reinjured his left knee and his claim was reopened.

In October 1986, Dr. Stanley performed arthroscopic surgery on claimant's left knee.

Claimant was examined by Dr. Erkkila, orthopedist, in January and February 1987. Erkkila had never previously examined claimant.

In April 1987, Dr. Stanley reexamined claimant. Thereafter, claimant continued to treat with Stanley, but not for his left knee condition.

A Determination Order reclosed claimant's claim in June 1987, awarding an additional 5 percent scheduled permanent disability.

Claimant's physical impairment is minimal. He can sit, stand, and walk without restriction. He can frequently lift up to 50 pounds. He can stoop, twist, and reach above the shoulder without restriction. In addition, he can frequently bend, squat, and climb.

Claimant's testimony concerning his level of left knee impairment is not reliable.

CONCLUSIONS OF LAW

Claimant must prove, by a preponderance of the evidence, that his loss of use or function in the left leg entitles him to a greater award of scheduled permanent disability than the 10 percent previously awarded by two Determination Orders. See Hutcheson v. Weyerhaeuser Co., 288 Or 51, 56 (1979).

Here, Dr. Stanley opined that claimant's permanent physical impairment was minimal and that he could perform any type of work. According to Stanley, claimant could frequently lift up to 50 pounds and sit, stand, and walk without restriction. On the other hand, Dr. Erkkila recommended extensive physical rehabilitation of claimant's left leg. If rehabilitation did not succeed, then Erkkila felt that further surgery might be necessary. However, Erkkila encouraged claimant to continue follow-up treatment with Dr. Stanley, inasmuch as Stanley was "intimately" familiar with the internal condition of his left knee.

Generally, we assign greater weight to the opinion of a worker's treating physician, unless there are persuasive reasons to do otherwise. Weiland v. SAIF, 64 Or App 810, 814 (1983). Here, there are no persuasive reasons to do otherwise. Dr. Stanley was claimant's treating surgeon and observed him on several occasions. Dr. Erkkila, however, observed claimant only twice. Accordingly, the opinion of Stanley is persuasive over that of Erkkila.

Moreover, a worker's permanent disability is evaluated as it exists at the time of the hearing. Gettman v. SAIF, 289 Or 609 (1980). Here, Erkkila last examined claimant in February 1987. Stanley, on the other hand, last examined claimant's left knee in April 1987. Thus, Stanley's opinion is also persuasive because it was based on a more recent evaluation of claimant's disability than was Erkkila's.

Claimant's testimony concerning his left knee impairment is inconsistent with Stanley's opinion. Although we consider claimant's testimony, including his complaints of pain, we find it unreliable.

ORDER

The Referee's order dated December 10, 1987 is affirmed.

BERTHA J. MINER, Claimant
Michael B. Dye, Claimant's Attorney
Beers, et al., Defense Attorneys

WCB 84-10842
June 2, 1988
Order on Review

Reviewed by Board Members Johnson and Crider.

The insurer requests review of Referee Peterson's order that: (1) awarded claimant temporary disability benefits for aggravation of her compensable knee injury; and (2) assessed a penalty and associated attorney fee for the insurer's unilateral termination of temporary disability benefits. In her brief, claimant asks the Board to increase the penalty from 10 percent to 25 percent.

ISSUES

On review, the issues are temporary disability, penalties and attorney fees.

FINDINGS

We adopt the Referee's "Findings of Fact" and make the following additional findings. The insurer terminated claimant's benefits because it believed she had withdrawn from the work force for reasons unrelated to her compensable injury. The insurer took this action in reliance on the Board's decision in Alexander M. Johnson, 38 Van Natta 1313 (1986), and the advice of its legal counsel. At the time of termination, claimant had not become medically stationary or returned or been released to return to regular work.

CONCLUSIONS AND OPINION

We affirm and modify the Referee's order.

The Referee decided that claimant had not returned to work as a direct result of her industrial injury. As a result, he concluded that the insurer's reliance on the Johnson decision was misplaced. Accordingly, he found that claimant was entitled to temporary disability benefits from the date of aggravation to claim closure.

We agree that the insurer's reliance on Johnson was misplaced. However, our reasons for this conclusion differ from those of the Referee.

Once an employer begins paying temporary disability benefits, it may not unilaterally terminate those benefits unless the worker has returned or been released to return to regular work by the treating physician, or the worker has become medically stationary and the claim has been closed by notice of closure or Determination Order. See Former ORS 656.268(2) and (3); Volk v. SAIF, 73 Or App 643, 646 (1985); Jackson v. SAIF, 7 Or App 109 (1971); Lloyd O. Fisher, 39 Van Natta 5 (1987).

In Johnson, supra, the Board held that an insurer was not required to pay interim compensation following an aggravation claim where: (1) the claimant had withdrawn from the work force for reasons unrelated to his compensable injury; (2) the insurer had never accepted the claim and had begun paying temporary disability; and (3) the insurer had no obligation to do so as the claimant had not established an aggravation.

In the present case, the insurer unilaterally terminated benefits after it had accepted claimant's aggravation claim and had begun paying temporary disability. Moreover, claimant had not returned or been released to return to regular work at the time the insurer terminated her benefits. Nor had she become medically stationary or had her claim closed by notice of closure or Determination Order. Under these circumstances, we find that the insurer's unilateral termination of benefits was improper. See Volk v. SAIF, supra.; Jackson v. SAIF, supra.; Lloyd O. Fisher, supra. Accordingly, we agree with the Referee that claimant is entitled to continuing temporary disability benefits until the date of claim closure.

Furthermore, we agree with the Referee's assessment of a penalty and associated attorney fee for the insurer's unilateral termination of benefits. However, we conclude that claimant is entitled to the maximum 25 percent penalty, rather than the 10 percent penalty assessed by the Referee.

If an insurer unreasonably refuses to pay compensation, it is liable for an additional amount, up to 25 percent of the amounts then due, plus a reasonable attorney fee. ORS. 656.262(10). A penalty is appropriate unless the insurer's refusal to pay was objectively reasonable in light of the available facts and existing law. See e.g., Volk v. SAIF, 73 Or App 643 (1985); Price v. SAIF, 73 Or App 123 (1985); Ginter v. Woodburn United Methodist Church, 62 Or App 118 (1983).

Here, the insurer's termination of benefits was clearly contrary to well-established law. ORS 656.268 admits of no exception to the procedural requirement that the insurer may not unilaterally discontinue payment of temporary disability benefits unless the claimant has been released to regular work or the claim has been closed by notice of closure or Determination Order after the claimant has become medically stationary. The courts have so held for many years. Volk v. SAIF, supra; Jackson v. SAIF, supra.

Where the law is in a state of flux, an insurer's reliance on a colorable interpretation of the law may be objectively reasonable. However, where the law is well established, as in the present case, an insurer's good faith reliance on an erroneous interpretation of the law is not sufficient to avoid a penalty. Moreover, a maximum 25 percent penalty is called for where the insurer unilaterally terminates benefits in violation of well-established law. See Jackson v.SAIF, 7 Or App 109 (1971). Accordingly, we increase the penalty assessed by the Referee from 10 percent to 25 percent.

ORDER

The Referee's order dated May 5, 1987 is affirmed in part and modified in part. The insurer is directed to pay

claimant a penalty equal to 25 percent of the additional temporary disability benefits awarded by the Referee's order. The remainder of the Referee's order is affirmed. We award claimant's attorney a $300 assessed fee for services on Board review regarding the temporary disability issue.

QUINN J. MURK, Claimant
SAIF Corp, Insurance Carrier

Own Motion 88-0272M
June 2, 1988
Own Motion Order

SAIF Corporation has submitted to the Board claimant's claim for an alleged worsening of his January 19, 1977 industrial injury. Claimant's aggravation rights have expired. SAIF opposes reopening of this claim as claimant's treatment has been of a conservative nature.

Pursuant to ORS 656.278(1)(a), we may exercise our "Own Motion" authority only when we find that there is a worsening of a compensable injury that requires either inpatient or outpatient surgery or other treatment requiring hospitalization. In such cases, we are authorized to award temporary disability compensation commencing from the time the worker is actually hospitalized or undergoes outpatient surgery. There is no provision under the law to allow increased permanent disability awards in own motion matters.

The evidence indicates that claimant's condition worsened temporarily and, with conservative treatment, he was able to return to work after three days off work. There is no evidence to indicate that claimant's condition required hospitalization for treatment or surgery. We conclude we are without authority to reopen this claim for the payment of further benefits. The request for own motion relief is hereby denied.

IT IS SO ORDERED.

MELINDA J. STEPHENS, Claimant
Brown & Tarlow, Claimant's Attorneys
Schwabe, et al., Defense Attorneys

WCB 87-12650
June 2, 1988
Order on Review

Reviewed by Board Members Ferris and Crider.

The insurer requests review of Referee Hettle's order that set aside its denial of claimant's occupational disease claim for a bilateral hand condition. We affirm.

ISSUE

On review, the issue is compensability.

FINDINGS OF FACT

We adopt the Referee's findings as supplemented.

The building where claimant worked was very cold. She wore heavy clothing and wrapped her legs in foam in order to keep warm. Other employees wore heavy clothing and coats to keep warm. Cold air from the outdoors came in through a door that was opened frequently. Claimant's work station was close to this door and she had greater exposure to the cold air than did her co-workers.

Claimant saw four doctors for her bilateral hand condition. According to her treating internist, Dr. Skipper, claimant's exposure to cold at work caused her preexisting bilateral hand condition to worsen and to become symptomatic. Another doctor said her condition was work related. The other two doctors did not discuss claimant's work or off-work activities. There was no contrary medical evidence produced.

Claimant's work exposure to cold worsened her underlying bilateral hand condition and caused it to become symptomatic.

CONCLUSIONS OF LAW AND OPINION

We adopt the Referee's analysis and opinion of the compensability issue as our own.

Claimant's counsel is statutorily entitled to a reasonable, carrier-paid attorney fee for services rendered on Board review. See ORS 656.382(2). Such a fee is defined as an "assessed fee". OAR 438-15-005(2). However, we cannot authorize an assessed fee unless claimant's counsel files a statement of services. See OAR 438-15-010(5). Because no statement of services has been received to date, an assessed fee shall not be authorized.

ORDER

The Referee's order dated December 21, 1987 is affirmed.

FRANK A. VILANJ, Claimant
Schwabe, et al., Defense Attorneys

WCB 87-12285
June 2, 1988
Order on Reconsideration

The insurer's counsel seeks Board authorization of a client-paid fee for services rendered which culminated in our May 3, 1988 Order on Review.

After review of the statement of services and attorney retainer agreement submitted by the insurer's counsel and considering the factors set forth in OAR 438-15-010(6) we approve a reasonable client-paid fee, not to exceed $516.

Accordingly, our May 3, 1988 order is abated and withdrawn. On reconsideration, as supplemented herein, we adhere to and republish our May 3, 1988 order in its entirety. The parties' rights of appeal shall run from the date of this order.

BRYAN D. WARRILOW, Claimant
Doblie & Associates, Claimant's Attorneys
Schwabe, et al., Defense Attorneys

WCB 86-09029
June 2, 1988
Order on Review

Reviewed by Board Members Johnson and Crider.

The self-insured employer requests review of that portion of Referee Thye's order that set aside its partial denial of claimant's current neck condition identified as "mild degenerative changes with mild osteophytic spurring." On review, the employer contends that the partial denial was issued

FINDINGS

On March 3, 1986 claimant suffered a compensable injury when a roller he was standing on gave way, causing him to fall. The next day, he sought chiropractic treatment, complaining of pain in the neck, left shoulder, mid back and left ankle. Time loss benefits were incurred because of the industrial injury.

X-rays revealed mild degenerative changes at C4-5 and C5-6 with mild osteophytic spurring. A myelogram reflected mild osteoarthritis in the cervical area, but did not suggest that claimant was experiencing a symptomatic cervical radiculopathy or a herniated disc. The degenerative changes and osteophytic spurring are unrelated to the work incident, but rather are consistent with claimant's age and lifestyle.

Claimant filed a workers' compensation claim describing the injury as one involving the "ankle, neck, shoulder (left)." The insurer deferred the claim. The insurer did not issue a written notice of acceptance of the claim within 60 days. On June 19, 1986, however, the insurer wrote claimant a letter saying:

> "We hereby accept that you did suffer an accident while engaged in your work activities on March 3, 1986. We will be responsible for any treatment related to the effects of this incident. We are going ahead and processing for payment the medical bills to date.
>
> "The x-rays taken at Mt. Hood Medical Center show mild degenerative changes with mild osteophytic spurring. Currently we have no medical evidence that these changes are related to your current condition or to your accident of March 3, 1986. Because these are not related to your injury, we must specifically deny responsibility for them.
>
> "This is a partial denial only, and does not affect the accepted portion of your claim. Again, we have paid the current medical bills, and will cover treatment related to the incident of 12/1/85."

The letter did not advise claimant whether the claim was considered disabling or nondisabling; nor did it inform claimant of his aggravation rights or the right to contest the characterization of a claim as nondisabling at a hearing. Furthermore, it did not inform claimant of his employment reinstatement rights under ORS Chapter 659; assistance available to employers from the Workers' Reemployment Reserve; or the entitlement to reimbursement of certain claim-related expenses. The letter did advise claimant of his hearing rights concerning the partial denial.

Claimant requested a hearing.

The Referee set aside the denial on the grounds that it was premature, claimant having made no claim for services related

CONCLUSIONS

We agree with the result reached by the Referee, although there is much that bears consideration in the Referee's analysis.

The Supreme Court has endorsed the practice of issuing partial denials when a claim has been made for two separate conditions and the insurer has accepted one condition but wishes to deny the other. Johnson v. Spectra Physics, 303 Or 49 (1987); Price v. SAIF, 296 Or 311 (1984); Ohlig v. FMC Marine & Rail Equipment Division, 291 Or 586 (1981). The Court has endorsed the practice because it relieves the insurer of the need to deny an entire claim in order to avoid acceptance of one or two or more separable conditions and assist in the prompt delineation and resolution of compensability issues. To that end, the Court has developed criteria for permissible partial denials:

> "The insurer may partially deny a claim if it specifies which injuries or conditions it accepts and which it denies. That specificity, which promotes timely closure of accepted conditions and prompt appeals of denied conditions, is the essence of a partial denial."

Johnson v. Spectra Physics, supra, at 58.

This case does not involve a procedurally proper partial denial. The denial letter issued in this case does not conform to the criteria specified in Johnson v. Spectra Physics, supra, because it was not preceded by an acceptance, nor was an acceptance executed contemporaneously, and therefore it could not distinguish with specificity that portion of the claim that was accepted from that portion that was denied. The letter did not include any information required by ORS 656.262(6) and former OAR 436-60-140 in a Notice of Acceptance.

Equally important, the letter did not tell claimant what condition was being accepted. Instead, it purported to accept "any treatment related to the effects of this incident" -- the "incident" being described variously in the letter as "an accident . . . on March 3, 1986" and "the incident of 12/1/85." The letter purports to satisfy the statutory requirement that claims be accepted or denied promptly and in writing, while utterly failing to do anything more than to concede that an accident occurred on the job. It preserves entirely the insurer's freedom to deny any particular condition or treatment as unrelated to "the accident." It does not in any way serve the purpose of ORS 656.262 which is to preclude insurers from paying on a claim for "extended periods of time, plac[ing] compensability in a holding pattern and then, as an after-thought, decid[ing] to litigate the issue of compensability." Bauman v. SAIF, 295 Or 788, 794 (1983).

The description of the accepted condition is the essence of a notice of acceptance. Claimant's rights under the claim are determined by that description. The insurer has accepted no more (Johnson v. Spectra Physics, supra) and no less (Piwowar v. Georgia Pacific, 305 Or 494 (1988)) than the condition described in the notice. No condition having been described and accepted by the June 19 letter, the letter did not satisfy the fundamental purpose of the notice of acceptance.

The insurer, having failed to issue an acceptance that meets either the procedural or the substantive requirements of an acceptance, may not issue a valid partial denial.

A partial denial must distinguish the accepted conditions from the denied conditions. The June 19 letter denied an allegedly pre-existing condition but accepted nothing. It is not a valid partial denial and must be set aside and the claim remanded to the insurer for processing. Accordingly, the Board affirms the order of the Referee.

Claimant's counsel is statutorily entitled to a reasonable, insurer-paid attorney fee for services rendered on Board review. See ORS 656.382(2).

The self-insured employer's counsel is statutorily entitled to a client-paid attorney fee for services rendered on Board review. See ORS 656.388(1). However, we cannot authorize a client-paid fee unless a Statement of Services is filed. See OAR 438-15-010(5). Because no Statement of Services has been received to date, a client-paid fee shall not be authorized.

ORDER

The Referee's order dated March 17, 1987 is affirmed. Claimant's attorney is awarded an assessed fee of $750, to be paid by the self-insured employer, for services on Board review.

DONN EDDY, Claimant
Bischoff & Strooband, Claimant's Attorneys
Richard C. Pearce, Defense Attorney

WCB 86-11859
June 3, 1988
Order on Review

Reviewed by Board Members Crider and Johnson.

The insurer requests review of those portions of Referee Smith's order that: (1) set aside its partial denial of claimant's degenerative talonavicular joint disease of the right foot and proposed bone spur excision surgery; (2) set aside its partial denial of claimant's psychiatric condition and need for psychiatric treatment; and (3) set aside two Determination Orders as premature.

The Board affirms the order of the Referee.

ISSUES

1. Whether claimant's degenerative talonavicular joint of the right foot and proposed bone spur excision surgery are compensable.

2. Whether claimant's psychiatric condition and need for psychiatric treatment are compensable.

3. Whether claimant's claim was prematurely closed by the July 1986 Determination Order.

4. Whether claimant's claim was prematurely closed by the May 1987 Determination Order.

FINDINGS OF FACT

Claimant compensably injured his right foot/ankle in

March 1985. Shortly thereafter, he was examined by Dr. Bald, orthopedist. X-rays of the right foot revealed a degenerative talonavicular joint with a large bony spur.

In October 1985, claimant was examined by Dr. Utterback, orthopedist. Utterback diagnosed degenerative changes in the talonavicular joint associated with a calcaneal-navicular bar. The talonavicular joint and calcaneal-navicular bar had become symptomatic due to the March 1985 injury.

Claimant underwent right foot surgery in December 1985 for resection of the calcaneal-navicular bar. Three and one-half weeks later, his cast was removed and he began a program of gradual weight bearing and physical therapy. In April 1986, he continued to experience right foot sensitivity and was still unable to stand for extended periods of time.

In July 1986, Dr. Bald reexamined claimant and noted continuing complaints of pain and lack of mobility in the right foot. Despite such continuing symptoms, Bald declared claimant medically stationary with a moderate level of permanent physical impairment. Shortly thereafter, claimant was examined by Dr. Butler, orthopedist. Butler took x-rays of claimant's right foot and diagnosed early arthritic changes in the tarsonavicular area accompanied by spur formation. He then scheduled claimant for a bone scan of both feet and ankles, which took place on July 29, 1986.

A Determination Order closed claimant's claim on July 30, 1986, with an award of 15 percent scheduled permanent disability.

In August 1986, claimant was examined by Dr. McNeil, orthopedist. McNeil reviewed the bone scan results and reported that claimant was still experiencing considerable pain in the right foot. The next day, McNeil recommended a talonavicular fusion. Although Dr. Butler concurred with McNeil, claimant was opposed to fusion surgery.

Claimant's claim was reopened later that month. Before proceeding with the talonavicular fusion surgery, Dr. Butler referred claimant to Dr. Griffin, psychiatrist. In August 1986, Griffin diagnosed an adjustment disorder with depression. A few months later, claimant was also evaluated by Dr. Cohen, psychiatrist.

In March 1987, the insurer issued a partial denial of claimant's psychiatric condition and all additional psychiatric care. Shortly thereafter, claimant's claim was reclosed by a Determination Order.

In May 1987, claimant began to treat with Dr. Cook, orthopedist, for continuing right foot pain. Cook recommended an evaluation by the Orthopaedic Consultants. The Consultants examined claimant in July 1987 and reported that claimant was receptive to bone spur removal surgery. Shortly thereafter, Cook requested authorization for excision of a large bony spur in the mid tarsal area of claimant's right foot.

Claimant's March 1985 injury was a material contributing cause to his existing right foot disability and need for bone spur excision surgery.

Claimant's March 1985 injury was a material contributing cause to his psychiatric condition and need for psychiatric treatment.

CONCLUSIONS OF LAW

1. Compensability of degenerative talonavicular joint and proposed bone spur excision surgery.

A worker's preexisting condition is compensable if an industrial injury causes it to produce symptoms thereby requiring medical services or resulting in disability. ORS 656.005(8); see Harris v. Albertson's, Inc., 65 Or App 254, 257 (1983). The industrial injury need not be the sole, or even the principal, cause of a worker's disability. Aquillon v. CNA Insurance, 60 Or App 231, 236 (1982). Further, a worker is entitled to all reasonable and necessary medical services related to his industrial injury. James v. Kemper Ins. Co., 81 Or App 80, 83 (1986); ORS 656.245(1).

The instant issue presents a complex medical question. Hence, although claimant's testimony is probative, resolution of the instant issue largely turns on the medical evidence. Uris v. Compensation Dept., 247 Or 420, 426 (1967); Kassahn v. Publishers Paper Co., 76 Or App 105, 109 (1985).

The Referee set aside the insurer's denial because he found that claimant's degenerative talonavicular joint had became symptomatic as a result of his compensable right foot injury. We agree.

Prior to claimant's compensable injury of March 1985, he was asymptomatic. Thereafter, however, he began to experience chronic right foot pain. X-rays taken shortly after the injury revealed "degenerative arthritis of the talonavicular joint with a large bony spur present in that region . . . ." Later, Dr. Utterback diagnosed a calcaneal-navicular bar and degenerative changes of the talonavicular joint. In so doing Utterback stated, inter alia:

> "there does not appear to be any doubt that symptomatology began with a distinct injury at work[,] and for that reason care should be continued via workman's compensation."

Bald concurred with Utterback's findings, remarking that claimant's navicular-bar had recently become symptomatic as a result of his March 1985 injury.

In December 1985, claimant underwent right foot surgery for resection of the calcaneal-navicular bar. The insurer accepted responsibility for the surgery.

The surgery was not successful, however, and claimant continued to experience pain in his right foot. Eventually he

In our view, claimant's industrial injury materially contributed to a symptomatic worsening of his preexisting talonavicular joint. Those symptoms required medical treatment and resulted in disability. See ORS 656.005(8)(a). After the first surgery, his symptoms continued. Drs. Butler, McNeil, and Cook all recommended a second surgery to alleviate claimant's continuing symptoms. Accordingly, we conclude that claimant's degenerative talonavicular joint and proposed bone spur excision surgery are compensable.

2. Compensability of psychiatric condition and need for psychiatric treatment.

To prove the compensability of a psychiatric condition related to a compensable injury, a worker must prove that the compensable injury materially contributed to his psychiatric condition. See Wilkerson v. Davila, 88 Or App 298 (1987). As above, the resolution of this issue requires expert medical opinion. Uris, supra; Kassahn, supra.

Here, Dr. Griffin diagnosed claimant's psychiatric condition as including an adjustment disorder with depression. According to Griffin, the March 1985 injury had "created a great deal of tension and frustration in [claimant] . . . ." Similarly, Dr. Cohen opined that "the right foot injury played a substantial role in [claimant's] depression along with other major losses . . . ." These "other major losses" included the loss of several dogs and personal bankruptcy. It is well settled, however, that a work injury need not be the sole cause of a worker's disability; but rather, only a material contributing cause. Aquillon, supra, 60 Or App at 236; Chatfield v. SAIF, 70 Or App 62 (1984).

We find the uncontradicted expert opinions of Griffin and Cohen to be well reasoned and based on a complete history. See Somers v. SAIF, 77 Or App 259, 263 (1986). Accordingly, we agree with the Referee and find that claimant's March 1985 injury was a material contributing cause of his psychiatric condition and resulting need for psychiatric treatment.

3. Whether claimant's claim was prematurely closed by the July 1986 Determination Order.

A worker's claim shall not be closed if his condition has not become medically stationary. ORS 656.268(1). "Medically stationary" is defined as "no further material improvement would reasonably be expected from medical treatment, or the passage of time." ORS 656.005(17).

Here, Dr. Butler examined claimant on July 29, 1986, and ordered a bone scan. The following day, a Determination Order closed claimant's claim. On August 5, 1986, Dr. McNeil examined claimant and reported that "[h]e continues to have pain and aching." McNeil recommended a talonavicular fusion. Butler concurred.

We find that both McNeil and Butler expected further material improvement in claimant's right foot condition. Otherwise, Butler would not have ordered a bone scan and neither he nor McNeil would have recommended surgery. Accordingly, we agree with the Referee that claimant's claim was prematurely closed by the July 1986 Determination Order.

4. Whether claimant's claim was prematurely closed by the May 1987 Determination Order.

A worker's psychiatric condition should be considered in assessing whether his claim should be closed. Utera v. Department of General Services, 88 Or App 114 (1987).

At the time of the March 1987 Determination Order neither Griffin nor Cohen had declared claimant psychiatrically stationary. See ORS 656.268(1). In fact, both Griffin and Cohen had recommended further psychiatric treatment. Accordingly, we agree with the Referee that the March 1987 Determination Order prematurely closed claimant's claim.

ORDER

The Referee's order dated December 24, 1987 is affirmed. Claimant's attorney is awarded an assessed fee of $650, to be paid by the self-insured employer. The Board approves a client-paid fee not to exceed $1,218.75.

PHILIP M. OMMERT, Claimant
Velure & Yates, Claimant's Attorneys
Acker, Underwood, et al., Defense Attorneys

WCB 87-08220
June 3, 1988
Order on Review

Reviewed by Board Members Johnson and Crider.

Claimant requests review of that portion of Referee Thye's order that upheld the insurer's denial of claimant's "continued" chiropractic treatments for his low back condition. The insurer did not file a formal cross-request for review, but requests in its brief that we reverse the Referee's award of 7.5 percent (24 degrees) unscheduled permanent partial disability. The insurer argues that claimant has suffered no permanent disability.

ISSUES

1. Claimant's entitlement to continued chiropractic care.

2. Extent of unscheduled permanent disability, if any.

FINDINGS OF FACT

Claimant is a 34-year-old journeyman bookbinder whose work requires repetitive bending and twisting while lifting up to 50 pounds. He worked 7-1/2 hour days seven days per week. He gradually developed low back pain in June 1985, and he sought treatment with chiropractors Buttler and McMahon. They diagnosed lumbosacral sprain, myalgia, myofascitis, disc derangement, and cervical and thoracic strain.

Claimant was taken off work by Dr. Buttler from July 8 through July 12, 1985. He was released to return to work with no heavy lifting on July 13, 1985. Despite Dr. Buttler's restrictions, claimant apparently returned to his regular job.

From June 1985 through March 1986, claimant continued to work at his job without time loss due to back symptoms. Claimant also continued to treat with Drs. Buttler and McMahon.

A progressive exacerbation of symptoms culminated in claimant being removed from work again on April 2, 1986. Dr. Buttler released claimant to modified work as of May 12, 1986 with no heavy lifting or repetitious light to moderate lifting. On June 10, 1986, he was released to return to regular work with the aid of an electric lifting device.

Claimant suffered an additional exacerbation in October 1986. Dr. Buttler subsequently released him to moderate work. Claimant had returned to his normal job duties by February 13, 1987.

Dr. Buttler reported that claimant was medically stationary as of April 17, 1987. He restricted claimant from heavy lifting and prescribed continued palliative care on an as-needed basis.

A Determination Order issued on May 12, 1987 which did not award any permanent disability.

On June 1, 1987, the insurer denied continued chiropractic treatment as being neither curative nor palliative.

On June 30, 1987, Dr. Buttler reported that claimant's condition had improved enough to warrant a reduction in the frequency of treatment. Claimant began treating with Dr. Buttler twice per month.

On October 30, 1987, two weeks before hearing, claimant changed jobs to a different bindery where the work was less demanding and he did not have to work as much overtime.

A panel of the Independent Chiropractic Consultants, as well as Dr. Duncan, chiropractor, have examined claimant on behalf of the insurer and have opined that further chiropractic care is neither curative nor reasonable or necessary for palliative purposes.

Claimant's current chiropractic treatments are palliative not curative.

Claimant continues to experience shooting pains in his lower back; he cannot get comfortable; and he cannot sit or stand for prolonged periods of time. Dr. Buttler's treatments provide symptomatic relief lasting approximately 1-1/2 to 2 weeks. Claimant missed a treatment during the summer of 1987 which led to increased symptoms. However, claimant was able to work without time loss due to his back condition for a number of months prior to the hearing.

Claimant has a high school education. In addition to his present employment, he has sorted tires, assembled parts of campers, painted gas tanks and worked in the shipping department of a book bindery. He retains the ability to perform all but very heavy repetitive labor. After our de novo review of the medical and lay testimony, we find that claimant's level of impairment resulting from his low back condition is in the minimal-to-mild range.

Claimant is a credible witness based upon the content of his testimony.

CONCLUSIONS OF LAW AND OPINION

Extent of Unscheduled Permanent Disability

The Board affirms and adopts the Referee's opinion with regard to the extent of claimant's unscheduled permanent disability.

Denial of Chiropractic Treatments

For every compensable injury, the insurer shall provide medical services for conditions resulting from the injury for such period as the nature of the injury or the process of the recovery requires. ORS 656.245(1). Medical expenses for purely palliative purposes are recoverable where they are necessarily and reasonably incurred in the treatment of an injury for which permanent partial disability has been awarded. Wetzel v. Goodwin Brothers, 50 Or App 101, 108 (1981). It is claimant's burden to prove the reasonableness and necessity of treatment. McGary v. SAIF, 24 Or App 1083 (1976).

Dr. Buttler has stated that his periodic palliative treatments help keep claimant at work. Claimant has credibly testified that he continues to experience periodic low back symptoms and that these symptoms are relieved by the treatments which Dr. Buttler provides.

The Referee found that claimant first testified that the treatments relieved his pain for two to three days, and then later testified that the relief lasted 1-1/2 to 2 weeks. This purported inconsistency was an apparent factor in the Referee's conclusion to uphold the insurer's denial. However, our review of claimant's testimony discloses that the Referee misconstrued claimant's earlier testimony. Claimant actually testified that the relief from Dr. Buttler's treatments lasted until two to three days before Dr. Buttler's next treatment. Because claimant was treating twice per month, this testimony is entirely consistent with his later testimony to the effect that the relief lasted 1-1/2 to 2 weeks.

On review, the insurer argues that continuing care on a regularly scheduled basis, without regard to whether the patient thinks he needs such care, belies the notion that such care is either reasonable or necessary. We construe the insurer's argument to be that palliative care must occur on an as-needed basis in order to be reasonable and necessary. We reject such a rigid rule. The evidence is that a twice-per-month treatment regimen coincides appropriately with claimant's present symptoms and symptom relief.

Claimant testified that he missed one treatment during the summer of 1987. The insurer notes that claimant was able to continue working without time loss despite this missed appointment. The insurer asks us to infer from this fact that claimant does not require continuing treatments in order to remain employed. We reject this inference. Claimant credibly testified that he experienced notably increased symptoms as a result of this missed appointment.

The evidence persuades us that claimant's current chiropractic treatments help to relieve his pain and allow him to

continue working. See West v. SAIF, 74 Or App 317 (1985). The insurer's denial of continued treatments must be set aside.

Claimant's counsel is statutorily entitled to a reasonable, carrier-paid attorney fee for services rendered at hearing and on Board review. See ORS 656.386(1). Such a fee is defined as an "assessed fee." OAR 438-15-005(2). However, we cannot authorize an assessed fee unless claimant's counsel files a statement of services. See OAR 438-15-010(5). Because no statement of services has been received to date, an assessed fee shall not be authorized.

Similarly, we cannot approve a client-paid fee for the self-insured employer's counsel without an accompanying statement of services. See OAR 438-15-010(5). Because no statement of services has been received to date, a client-paid fee shall not be authorized.

ORDER

The Referee's order dated December 18, 1987 is affirmed in part and reversed in part. The insurer's denial dated June 1, 1987 is set aside and the medical services claim is remanded to the insurer for processing according to law. The remainder of the Referee's order is affirmed.

DAN V. O'NEIL, Claimant
Welch, et al., Claimant's Attorneys
Schwabe, et al., Defense Attorneys

WCB 87-11948
June 3, 1988
Order on Review

Reviewed by Board Members Crider and Johnson.

Claimant requests review of Referee Shebley's order that affirmed a Determination Order which awarded him 30 percent (45 degrees) scheduled permanent disability for loss of use or function of his left hand. On review, claimant contends that he is entitled to a greater award of scheduled permanent disability for his left hand and forearm, as well as a scheduled permanent disability award for his left arm.

The Board affirms and adopts the order of the Referee.

The insurer's counsel seeks Board authorization of a client-paid fee for services rendered on review.

After review of the statement of services and the attorney referral letter in this particular case, and considering the factors set forth in OAR 438-15-010(6), we approve a client-paid fee, not to exceed $539. In so doing, we note that all attorney fees are subject to Board approval. OAR 438-15-001. However, costs incurred by an attorney in pursuing a matter on behalf of a party are not included in fees paid to any attorney. OAR 438-15-005(7). Therefore, Board approval for reimbursement of costs incurred by the attorney is not required. See OAR 438-15-005(4), (5), (7); OAR 438-15-010(5); Janelle I. Neal, 40 Van Natta 359 (April 21, 1988).

ORDER

The Referee's order dated December 31, 1987 is affirmed. The Board approves a client-paid fee not to exceed $539.

RICARDO APODACA, Claimant
Brian Whitehead, Claimant's Attorney
SAIF Corp Legal, Defense Attorney

Own Motion 88-0297M
June 8, 1988
Own Motion Order

SAIF Corporation has submitted to the Board claimant's claim for an alleged worsening of his February 22, 1978 industrial injury. Claimant's aggravation rights have expired. SAIF opposes reopening of this claim for the payment of temporary total disability compensation as there is no evidence claimant requires hospitalization for treatment or inpatient or outpatient surgery and because it feels claimant has removed himself from the work force.

Dr. Lawton, a chiropractor, has indicated that claimant's condition has materially worsened and he should be receiving temporary total disability compensation. Pursuant to ORS 656.278(1)(a), we may exercise our "Own Motion" authority only when we find that there is a worsening of a compensable injury that requires either inpatient or outpatient surgery or other treatment requiring hospitalization. In such cases, we are authorized to award temporary disability compensation commencing from the time the worker is actually hospitalized or undergoes outpatient surgery. To date, there is no indication that any of the above treatment modalities have been recommended in this case. We conclude, therefore, we are without authority to grant own motion relief to claimant. The request for own motion relief is hereby denied.

IT IS SO ORDERED.

PAUL M. JOHNSON, Claimant
Michael B. Dye, Claimant's Attorney
Meyers & Terrall, Defense Attorneys

WCB 87-09212
June 8, 1988
Order on Review

Reviewed by Board Members Ferris and Crider.

Claimant requests review of Referee Higashi's order that: (1) found that claimant's left ear and neck injury claim was untimely filed; (2) upheld the self-insured employer's denials of the same condition; and (3) declined to assess a penalty and associated attorney fee for unreasonable denial. Claimant further requests that we remand this case to the Hearings Division for consideration of additional evidence. We decline to remand the case. On the merits, we reverse that portion of the order that found the claim time barred. We affirm the remainder of the order.

ISSUES

1. Compensability of claimant's right ear and neck condition.

2. Penalties and attorney fees for unreasonable denial.

3. Timeliness of claimant's notice of injury to employer.

4. Remand for consideration of additional evidence.

FINDINGS OF FACT

Claimant, 31 years old at the time of hearing, had been employed on-and-off for five years as a truck driver for the

employer. His delivery route involved dispatch from Salem, Oregon to various Idaho delivery locations. On February 3, 1987, claimant filed a claim for an injury which allegedly occurred while unloading freight in Pocatello, Idaho in approximately mid-August 1986. Claimant's Form 801 indicates that, during the unloading process, he was struck on the left side of his face by a box of bleach.

On September 5, 1986, claimant began treatments with Dr. Layman, chiropractor, for a painful and stiff neck. Claimant also complained of dizziness and light-headedness. Claimant made no mention of the alleged accident to Dr. Layman. Dr. Layman diagnosed acute cervical strain with possible associated inner ear symptoms and temporomandibular joint dysfunction. He subsequently opined that claimant's reported history of the incident "supported the injury".

On September 9, 1986, claimant was examined by Dr. Huewe, an ear, nose and throat specialist. Claimant reported ringing, pain and bubbling in his left ear. He also reported having experienced similar problems three to four times in the past. Claimant did not mention the alleged August incident. Dr. Huewe was unsure as to a diagnosis of claimant's condition, although he suspected a eustachian tube problem, a healed fistula, or a dental problem. He did not feel that claimant's condition warranted exploration or specific therapy.

On November 11, 1986, claimant saw his regular dentist, Dr. Friess, complaining of swelling and a feeling of pressure in the left ear. Claimant reported a work-related incident to Dr. Friess. Dr. Friess subsequently opined that it was highly probable the mid-August incident precipitated claimant's condition.

Claimant took a short vacation to Bend, Oregon on or about August 23, 1986. His symptoms first appeared during this trip while descending from high altitude in his car.

Claimant did not give notice of an accident resulting in injury until February 3, 1987. The employer had no knowledge of an injury until this date.

Claimant was an unreliable witness.

CONCLUSIONS OF LAW AND OPINION

The Referee denied relief to claimant on alternate grounds. He first concluded that claimant had failed to prove he was injured in an on-the-job accident involving falling freight. Alternatively, he found that the claim was time barred because claimant failed to give notice to his employer of the accident giving rise to his injuries. We disagree with the Referee's finding on the timeliness issue, but we affirm on the alternative issue of the lack of proof of an on-the-job injury.

Timeliness of Notice

Subject to certain expressly enumerated exceptions, ORS 656.265 requires that an injured worker give his employer notice of an injury not later than 30 days after the accident. Claimant alleges an August 1986 injury. However, he did not file a claim with the employer until February 3, 1987, well beyond 30 days of the date of injury. The Referee concluded that the claim was barred due to claimant's failure to give notice within 30 days.

We have previously found that the employer did not have knowledge of an "injury" suffered by claimant that was possibly attributable to his work activities until well after the expiration of 30 days from the alleged incident. See ORS 656.265(1). In addition, the evidence fails to establish "good cause" for claimant's failure to file his claim before February 3, 1987. We note in this regard that claimant was aware of a possible connection between his condition and the alleged incident not later than November 11, 1986. See ORS 656.265(4)(c). We conclude, however, that the employer was not prejudiced by its failure to receive timely notice. See ORS 656.265(4)(a).

The employer bears the burden of proving that there has been prejudice from untimely notice. Inkley v. Forest Fiber Products Co., 288 Or 337 (1980). The passage of time is not sufficient to show prejudice; the employer must prove some actual prejudice. Ford v. SAIF, 71 Or App 875 rev den 299 Or 118 (1985).

The employer argues that if notice had been timely given, the employer and its claims processor could have promptly interviewed witnesses, checked accessible records, and obtained medical examinations. However, the record discloses that even after receipt of notice of the claim, the employer did not promptly interview witnesses, check records or obtain medical examinations. Instead, several months elapsed before such attempts at evidence gathering were undertaken. Consequently, we are not persuaded that the employer has proven actual prejudice as a result of untimely notice of the accident. Thus, the claim was not barred by failure to give notice within 30 days of the injury.

Occurrence of a Compensable Injury

The Referee was unpersuaded that claimant had suffered an on-the-job injury giving rise to his complaints. We are similarly unpersuaded.

Claimant's testimony regarding his date-of-injury is markedly ambiguous. Until hearing, claimant consistently reported that the incident occurred in mid-August 1986. His Form 801 cites a mid-August 1986 injury date. Dr. Layman's reports also refer to a mid-August 1986 injury date. A Change-of-Physician form submitted by Dr. Stober, chiropractor, notes an August 21, 1986 injury date.

Claimant offered no independent evidence at hearing to corroborate this injury date. Instead, the evidence introduced at hearing indicates that claimant's only August 1986 trip to Pocatello occurred on August 27, 1986. This is after claimant's August 23, 1986 vacation trip to Bend where his symptoms first appeared. When confronted with this evidence, claimant testified that he was unsure when he made the trip to Bend. However, claimant previously testified repeatedly that he went to Bend on or around August 23, 1986.

Claimant testified that he kept personal logs as to his trips. Such logs could perhaps have established an accurate injury date if they had been offered into evidence. They were not.

Claimant initially testified that his co-driver on the Pocatello trip was named McCloskey. He further testified that he informed McCloskey of the incident. However, McCloskey did not testify at hearing. Furthermore, when claimant was shown a copy

of the employer's log entry for his August 27, 1986 Pocatello trip, the entry indicated that claimant's co-driver was someone other than McCloskey. At that point, claimant testified that he was not certain who his partner was on the Pocatello trip.

Given these inconsistencies, we cannot rely on claimant's testimony to establish that a work-related incident occurred nor can we rely on the physician's reports based on claimant's history to establish that his reported symptoms were caused by that incident.

In sum, we agree with the Referee that there is simply insufficient credible evidence to find that claimant was injured in an on-the-job accident involving falling freight.

Motion to Remand

Accompanying his reply brief, claimant submits a motion for remand to consider "newly-discovered evidence." The evidence consists of a credit memo which, claimant asserts, corroborates his version of the August incident. The credit memo refers to three sets of items damaged on delivery to Pocatello, each with an August 26, 1986 invoice date. Claimant testified that he was struck in the face by a box of bleach. None of the items is bleach, although two of the items are similar household goods.

We may remand if we determine that a case has been improperly, incompletely or otherwise insufficiently developed or heard by the Referee. ORS 656.295(5). Claimant asserts that we should remand because the credit memo represents newly-discovered evidence which should have been produced earlier by the employer.

The employer argues the credit memo is not a claims or medical document, nor a personnel record or document from a personnel file within the meaning of the request made by claimant. We agree with the insurer. OAR 438-07-015(2), relied upon by claimant, mandates that the insurer furnish claimant "all medical and vocational reports, records of compensation paid, and other documents pertaining to the claim(s)...." (emphasis added) We do not find that the credit memo was a document "pertaining to the claim." After conducting our de novo review, we find that the record has not been "improperly, incompletely, or otherwise insufficiently developed."

Moreover, the record below was closed on December 9, 1987. The credit memo was the subject of a November 16, 1986 hearing before the employer's credit department. Claimant must, therefore, have had notice of the memo prior to closing of the record. We conclude that it has not been shown that the memo was unobtainable with due diligence before the hearing was held and the record was closed. See Bernard L. Osborn, 37 Van Natta 1054, 1055 (1985), aff'd mem. 80 Or App 152 (1986).

ORDER

The Referee's order dated December 24, 1987 is reversed in part and affirmed in part. That portion of the Referee's order that found the claim to be time barred is reversed. The remainder of the order is affirmed. A client-paid fee not to exceed $885.50 is approved.

DAVID H. RAYMOND, Claimant
Pozzi, et al., Claimant's Attorneys
Roberts, et al., Defense Attorneys
Rankin, et al., Defense Attorneys

WCB 87-01143 & 87-01144
June 8, 1988
Order of Dismissal

Claimant's treating chiropractor, Dr. Bolera, has requested Board review of Referee St. Martin's November 24, 1987 order, as reconsidered January 15, 1988. We have reviewed the request to determine whether we have jurisdiction to consider the matter. We conclude that we lack jurisdiction.

FINDINGS

The Referee's order issued November 24, 1987. Following a request for reconsideration, the Referee issued an abatement order on December 22, 1987. An Order on Reconsideration issued January 15, 1988. On May 19, 1988, the Board received Dr. Bolera's May 16, 1988 request for review of the Referee's order. The request did not include an acknowledgment of service nor a certificate of personal service by mail upon any party to the proceeding before the Referee.

Claimant's treating chiropractor's request for review was filed with the Board more than 30 days after the date of the Referee's order.

CONCLUSIONS

A Referee's order is final unless, within 30 days after the date on which a copy of the order is mailed to the parties, one of the parties requests Board review under ORS 656.295. ORS 656.289(3). "Party" means a claimant for compensation, the employer of the injured worker at the time of injury and the insurer, if any, of such employer. ORS 656.005(19). 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).

The time within which to appeal an order continues to run, unless the order has been "stayed," withdrawn, or modified. International Paper Co. v. Wright, 80 Or App 444 (1986); Fischer v. SAIF, 76 Or App 656, 659 (1986). In order to abate and allow reconsideration of an order issued under ORS 656.289(1), at the very least, the language of the second order must be specific. Farmers Insurance Group v. SAIF, 301 Or 612, 619 (1986).

Inasmuch as the Referee's January 15, 1988 Order on Reconsideration has neither been abated, withdrawn, stayed, modified, republished, nor appealed within 30 days of its issuance, it has become final by operation of law. ORS 656.289(3); Farmers Insurance Group v. SAIF, supra; International Paper Co. v. Wright, supra; Fischer v. SAIF, supra. Furthermore, Dr. Bolera is not a "party." Therefore, even if the request for review was timely filed with timely notice to all parties, Dr. Bolera can not validly request Board review. See ORS 656.005(19); 656.289(3). Under these circumstances, we lack jurisdiction to review the Referee's order. Accordingly, the request for Board review is dismissed.

IT IS SO ORDERED.

EINAR SATHER, Claimant
Phillip H. Garrow, Claimant's Attorney
SAIF Corp Legal, Defense Attorney

Own Motion 88-0303M
June 8, 1988
Own Motion Order

SAIF Corporation has submitted to the Board claimant's claim for an alleged worsening of his March 28, 1974 industrial injury. Claimant's aggravation rights have expired. SAIF has authorized the recommended surgery but opposes reopening of this claim for the payment of temporary total disability compensation as it contends claimant has been removed from the work force.

Pursuant to ORS 656.278(1)(a), we may exercise our "Own Motion" authority when we find that there is a worsening of a compensable injury that requires either inpatient or outpatient surgery or other treatment requiring hospitalization. In such cases, we are authorized to award temporary disability compensation commencing from the time the worker is actually hospitalized or undergoes outpatient surgery.

Pursuant to ORS 656.278 claimant may be entitled to compensation for temporary total disability as he does intend to undergo surgery. However, our record indicates that claimant has been receiving social security disability benefits since 1976 and that, for at least the past two years, this was his sole income. We must conclude that claimant has removed himself from the work force and is not entitled to compensation for temporary total disability during his recovery from surgery. Cutright v. Weyerhaeuser Company, 299 Or 290 (1985), and Karr v. SAIF, 79 Or App 250 (1986). The request for own motion relief is hereby denied.

IT IS SO ORDERED.

ORVILLE D. SHIPMAN, Claimant
Bloom, et al., Claimant's Attorneys
Lindsay, et al., Defense Attorneys

Own Motion 87-0680M
June 8, 1988
Own Motion Order on Reconsideration

Claimant has requested reconsideration of our March 16, 1988 Own Motion Order which concluded that we lacked authority to grant claimant's request for permanent total disability. We reasoned that because claimant's injury claim was currently closed, his request for Own Motion relief must be considered under the present version of ORS 656.278(1)(a), which became effective January 1, 1988. Inasmuch as we lack authority to award permanent partial or permanent total disability under the aforementioned statute, we denied claimant's request.

Claimant contends that the Board failed to consider the law in effect at the time of claimant's 1973 injury. In support of his contention, claimant cites ORS 656.202(2), which provides that:

> "Except as otherwise provided by law, payment of benefits for injuries or deaths under ORS 656.001 to 656.794 shall be continued as authorized, and in the amounts provided for, by the law in force at the time the injury giving rise to the right to compensation occurred."

Furthermore, claimant submits that House Bill 2900 (which became Oregon Laws 1987, Chapter 884) did not amend, modify or

otherwise alter the aforementioned statute. Consequently, claimant asserts that the Board's Own Motion authority in this claim is not limited by Section 37 of Chapter 884. (Which amended ORS 656.278(1) by limiting awards to temporary disability compensation from the time the worker is actually hospitalized or undergoes outpatient surgery until the worker's condition becomes medically stationary as determined by the Board).

Contending that the Board had authority to award additional permanent partial or permanent total disability at the time of his 1973 injury and at the time of his 1987 request for Own Motion relief, claimant argues that the Board is empowered to grant his request. We disagree.

Section 37 of Chapter 884, which amended ORS 656.278(1) as previously described, became operative January 1, 1988. See Section 63. Moreover, these amendments became operative on January 1, 1988, "[n]otwithstanding ORS 656.202." See Oregon Laws 1987, Chapter 884, Section 62. (Emphasis added).

In addition to the amendments to ORS 656.278(1), Chapter 884 also created ORS 656.625, the "Reopened Claims Reserve." See Oregon Laws 1987, Chapter 884, Section 39. ORS 656.625(1) provides that the Director "shall establish a Reopened Claims Reserve within the Insurance and Finance Fund for the purpose of reimbursing the additional amounts of compensation payable to injured workers that results from any award made by the board pursuant to ORS 656.278 after January 1, 1988." ORS 656.625(2) further states that "[n]otwithstanding any other provision of law, any reimbursement from the Reopened Claims Reserve shall be in such amounts as the board prescribes and only to the extent that funds are available in the reserve." As with the other sections of Chapter 884, Section 39 became operative January 1, 1988. See Chapter 884, Section 63.

The language of the aforementioned statutes unambiguously expresses the intent of the legislature that the Board's authority to award compensation after January 1, 1988 is limited to temporary disability benefits. Thus, it is not necessary to resort to statutory construction principles or to legislative history to determine the intent of the legislature. Whipple v. Howser, 291 Or 475 (1981). Even assuming that ambiguities exist, the legislative history supports the conclusion that the legislature intended to limit all awards for claims in which the worker's aggravation rights had expired to temporary disability only and to create a reserve for the payment of such benefits. See Minutes, Senate Committee on Labor, Pages 30 - 35, (June 10, 1987).

Finally, claimant objects to the issuance of our order with notice of appeal rights pursuant to ORS 656.278(3). At a minimum, claimant suggests that our order be modified to allow him the right to petition for judicial review. We are without authority to grant claimant's request.

Inasmuch as claimant has requested relief under our Own Motion authority, we are obliged to issue an order pursuant to that authority. Therefore, in accordance with ORS 656.278(3), we are required to advise the parties of their respective rights of appeal from our Own Motion order.

Accordingly, the request for reconsideration is granted. On

reconsideration, as supplemented herein, we adhere to and republish our March 16, 1988 order, effective this date. A client-paid fee, not to exceed $583.50, is approved.

IT IS SO ORDERED.

The Beneficiaries of
ROY D. BEEBE (Deceased), Claimant
Thomas Howser, Claimant's Attorney
Cowling & Heysell, Defense Attorneys

WCB 86-11931
June 10, 1988
Order on Review

Reviewed by Board Members Johnson and Crider.

The insurer requests review of that portion of Referee Melum's order that set aside its denial of the beneficiaries' claim for the deceased worker's death by pulmonary embolism. The issue is compensability.

The Board affirms and adopts the order of the Referee.

Claimant's attorney is entitled to an insurer-paid attorney fee for services at the hearing and on Board review under ORS 656.382(2). See Greenslitt v. City of Lake Oswego, 305 Or 530, 536 n.4 (1988). A fee awarded under ORS 656.382(2) is an assessed fee within the meaning of OAR OAR 436-15-005(2). The Board may not award an assessed fee until it receives and considers a statement of services from the claimant's attorney. OAR 438-15-010(5). To date, no statement of the services rendered by claimant's attorney at the hearing and Board levels has been received. No fee, therefore, can be awarded at this time.

ORDER

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

JAMES G. CRUICKSHANK, Claimant
John L. Lannan, Claimant's Attorney
Thomas Sheridan (SAIF), Defense Attorney

WCB 87-07939
June 10, 1988
Order on Review

Reviewed by Board Members Ferris and Crider.

Claimant requests review of Referee Tuhy's order that: (1) upheld the SAIF Corporation's denial of his low back claim; and (2) declined to assess a penalty and attorney fees for an alleged unreasonable denial. No briefs were submitted on Board review. We affirm.

ISSUES

1. Compensability of claimant's low back condition.

2. Penalties and attorney fees for alleged unreasonable denial.

FINDINGS OF FACT

Claimant was employed as an apprentice plumber. He was the only employee of the company other than the owner. His job duties were generally strenuous and often required lifting overhead more than 100 pounds in sometimes awkward positions. Prior to the incidents giving rise to his claim, claimant had experienced occasional low back pain. This pain had generally resolved within a few days.

Claimant experienced the gradual onset of low back pain in mid-January 1987. He continued to work on and off for the next week or two.

On January 25, 1987, claimant went with his father-in-law, a veterinarian, to rescue a cow which had calved and become stuck between stalls. One of the tasks involved in freeing the cow was removal of a post. This required pushing the post back and forth in order to widen the hole to remove it. Claimant took an active role in removing the post. The work was strenuous. It lasted 20 to 30 minutes.

After returning home that evening, claimant experienced notably increased pain located in the same area as before. Claimant did not return to work the following week. He then worked for only a half day during the next several weeks. He was eventually taken off work by Dr. Paxton.

An MRI scan in February 1987 revealed a herniated disc. Dr. Paxton performed surgery on the herniated disc in mid-April 1987.

Claimant delayed filing a claim and seeking medical treatment. He did so because he believed his symptoms would subside.

CONCLUSIONS OF LAW AND OPINION

We adopt the Referee's opinion.

ORDER

The Referee's order dated September 9, 1987 is affirmed.

DESI R. DAVIS, Claimant
Bischoff & Strooband, Claimant's Attorneys
Cowling & Heysell, Defense Attorneys

WCB 87-08233
June 10, 1988
Order on Review

Reviewed by Board Members Crider and Ferris.

The insurer requests review of Referee Quillinan's order which set aside its denial of claimant's claim for a low back condition. The insurer further contends that the Referee lacked jurisdiction to issue an Order On Reconsideration which increased claimant's attorney fee. We reverse in part and affirm in part.

ISSUES

1. Compensability
2. Jurisdiction

FINDINGS OF FACT

On April 13, 1987, claimant, a gas station attendant and manager, was squatting down to replace a gas cap on a car when her left knee "popped," causing pain. She alleges that she also developed sharp pains along the left leg from hip to foot. She nevertheless completed her work shift and returned to work the following day. Later that day, she went to the hospital emergency room with the lone complaint of left knee pain. Dr. Minser, the emergency room physician, noted some tenderness and discomfort

along the left knee, though x-rays of the knee were normal. Minser referred claimant to Dr. Chamberlain, an orthopedist. Claimant did not return to work.

Claimant alleges that, during the day following the industrial accident, she developed additional symptoms of pain in her low back and right hip. On April 17, 1987, claimant filed a claim for a left knee injury only. That claim was accepted.

Claimant was examined once by Dr. Chamberlain, on April 20, 1987. Claimant alleges that, at the time of that examination, the pain in her low back and right hip was more severe than that in the left leg and knee. Yet, she told Chamberlain of her left knee symptoms only. She explained that Chamberlain never asked about other symptoms. Chamberlain's examination revealed no abnormalities in the knee.

Claimant subsequently consulted with Dr. Schefstrom, a chiropractor. During that initial consultation, Schefstrom examined claimant's left knee and found no remarkable abnormalities. He then examined claimant's low back and, based on that examination, recommended that she return for another appointment.

Claimant transferred her care to Dr. Schefstrom on April 30, 1987. At that time, claimant complained of knee "popping," pain radiating into the buttocks, burning pain in the hips, and low back pain radiating into the ankle. Schefstrom diagnosed acute lumbosacral strain, with associated radiculitis, deep muscle spasms and facet irritation, and sacroiliac strain with radiculitis. Schefstrom began conservative treatment, including manipulation. Schefstrom never treated the left knee.

Viewing Dr. Schefstrom's initial report as a claim, the insurer denied the compensability of the low back strain on May 21, 1987.

We are unable to find that claimant's low back strain was caused by the industrial accident on April 13, 1987.

By Opinion and Order on December 24, 1987, the Referee set aside the insurer's denial and awarded claimant's attorney a $1,000 attorney fee for prevailing over the denial. Claimant's attorney timely requested reconsideration of the attorney fee award. The request was accompanied by a motion for an order of abatement. Without abating the original order, the Referee issued an Order On Reconsideration on January 13, 1988, increasing claimant's attorney fee to $1,400. The insurer's request for Board review was received on January 14, 1988.

CONCLUSIONS AND OPINION

Compensability

Claimant bears the burden of proving by a preponderance of the evidence that an industrial injury materially contributed to her disability or need for medical treatment. Hutcheson v. Weyerhaeuser, 288 Or 51, 56 (1979); Milburn v. Weyerhaeuser Company, 88 Or App 375, 378 (1987). Stated differently, claimant must prove that the industrial incident on April 13, 1987, materially contributed to her low back condition.

The only medical opinion on causation was provided by Dr. Schefstrom, who opined that the April 13 incident caused the low back condition and the resultant need for medical treatment. In so opining, Schefstrom relied on claimant's history that she developed strain-type symptoms in the low back and lower extremities shortly after the industrial accident. Claimant repeated that history in her testimony at hearing.

The central dispute here concerns claimant's credibility. The Referee made no credibility finding. After our review of the record, we find that claimant was not credible. We base our finding on irreconcilable inconsistencies between claimant's testimony and the documentary evidence.

First, claimant testified that she developed pain in her low back and right hip shortly after the accident; yet, she filed a claim for the left knee injury only. Second, claimant testified that her low back and right hip pain was more severe than that in her left knee when she saw Dr. Chamberlain; yet, she reported the knee pain, without mentioning the more severe symptoms. We find it incredible that claimant suffered severe back and hip pain, yet failed to mention these symptoms in her initial claim or to Dr. Chamberlain.

Furthermore, Dr. Schefstrom recalled during his post-hearing deposition that claimant initially consulted him for left knee problems and that he examined her back only after his examination of the knee yielded no remarkable findings. He further recalled that he invited claimant back when he discovered back problems. Claimant subsequently changed her care to Schefstrom by completing a Form 829 (Change of Attending Physician). That form, completed on April 30, 1987, is the earliest documentary evidence of claimant's back and hip symptoms. We find it incredible that claimant delayed reporting his back and hip symptoms for more than two weeks after their alleged onset.

Finally, we note that the history recited by Dr. Schefstrom during his deposition differed from claimant's testimony and the documentary evidence. According to Schefstrom, claimant told the previous doctors, including Chamberlain, of her back and hip symptoms, but they felt that those symptoms were secondary to her knee injury and altered gait. Claimant testified, however, that she never told the previous doctors of those symptoms. The documentary evidence shows likewise. Indeed, the documentary evidence shows that Chamberlain found nothing wrong with the left knee; therefore, it is unlikely that he attributed back and hip symptoms to the knee. The foregoing suggests that claimant gave an incorrect history to Dr. Schefstrom.

Given our credibility finding, we decline to rely on medical evidence which is based on claimant's history. Dr. Schefstrom's opinion is therefore not persuasive. Accordingly, we conclude that claimant has not sustained her burden of proving that the industrial accident was a material contributing cause of her low back condition. Her low back injury claim was not compensable.

Jurisdiction

The insurer contends that the Referee lacked jurisdiction to issue the Order On Reconsideration dated

January 13, 1988, reasoning that jurisdiction was divested by the alleged simultaneous filing of its request for Board review. We disagree.

"Filing" means the physical delivery of a thing to the Board's office, or the date of mailing. OAR 438-05-046(1)(a). If filing of a request for Board review is accomplished by registered or certified mail, the mailing date of the request is presumed to be the date shown on a receipt for such mail. OAR 438-05-046(1)(b). If the request is not mailed by registered or certified mail and the request is actually received by the Board after the date for filing, the mailing is presumed to be untimely unless the filing party establishes that mailing was timely. Id.

The above rules clearly provide that a review request which is not mailed by registered or certified mail is presumed to have been mailed on the date of actual receipt. Here, the insurer's request for review was mailed by first class mail, postage prepaid, and was received on January 14, 1988. The insurer has offered no evidence that the mailing occurred on an earlier date. We conclude, therefore, that the insurer's review request was filed on January 14, 1988, a day after issuance of the Order On Reconsideration. Even if the Referee's Order on Reconsideration and the request for Board review were filed simultaneously, we would give effect to the act that results in the resolution of the controversy at the lowest possible level. See James D. Whitney, 37 Van Natta 1463 (1985). Consequently, we conclude the Referee properly exercised her jurisdiction in issuing the Order On Reconsideration.

ORDER

The Referee's order dated December 24, 1987, as reconsidered on January 13, 1988, is affirmed in part and reversed in part. That portion of the order which set aside the insurer's denial of claimant's low back injury claim is reversed. That denial is reinstated. The remainder of the order is affirmed.

BUDDY A. FLICKINGER, Claimant
Charles D. Maier, Claimant's Attorney
Davis & Bostwick, Defense Attorneys

WCB 86-18024
June 10, 1988
Order on Review

Reviewed by Board Members Johnson and Crider.

The insurer requests review of Referee Borcher's order that increased claimant's unscheduled permanent disability award for an upper back and neck condition from 20 percent (64 degrees), as awarded by a Determination Order, to 35 percent (112 degrees). We affirm.

ISSUE

On review, the issue is extent of unscheduled disability.

FINDINGS OF FACT

On June 21, 1985, claimant, who was employed as a furniture mover, incurred a compensable injury to his upper back and neck when he was crushed between two trucks.

Claimant has a history of injury to his low back. In

August 1981, he underwent fusion surgery. This injury and resulting surgery were resolved prior to the 1985 compensable injury.

Claimant's treating physician is Dr. Jansen, chiropractor. He diagnosed acute severe upper back sprain/strain and moderate neck sprain/strain. Dr. Jansen prescribed chiropractic manipulation, physical and physio therapy and took claimant off work. Ultimately, Dr. Jansen reported claimant suffered moderate impairment. Claimant was limited to not lifting over 20 pounds, not carrying over 25 pounds, no pushing and pulling, no crawling and only occasional bending, squatting and climbing. He was also limited to driving no more than 20 miles per round trip.

The Orthopaedic Consultants examined claimant on the insurer's behalf. In a November 1985 letter they diagnosed dorsal and cervical spine strain and concluded that the claim could be closed after six weeks of intensive exercise.

Claimant continued to be examined by neurologists and orthopedists.

Claimant, 36 years of age at the time of hearing, a ninth grade education and an employment history comprised of heavy labor. He received vocational rehabilitation services which placed him in an on-the-job training program performing pest control services. At this time, he attended some community college courses.

The classroom work caused claimant back and neck pain. The pest control job required claimant to drive 50 miles to and from work, crawl under houses, repeatedly bend and squat. These activities caused claimant upper back and neck pain.

A June 3, 1987 Determination Order awarded claimant 20 percent (64 degrees) unscheduled permanent disability. At the time of hearing, claimant had part-time employment as a janitor that did not involve heavy lifting.

CONCLUSIONS OF LAW AND OPINION

We adopt the Referee's opinion.

Claimant's counsel is statutorily entitled to a reasonable, carrier-paid attorney fee for services rendered on Board review. See ORS 656.382(2). Such a fee is defined as an "assessed fee." OAR 438-15-005(2). However, we cannot authorize an assessed fee unless claimant's counsel files a statement of services. See OAR 438-15-010(5). Because no statement of services has been received to date, an assessed fee shall not be authorized.

ORDER

The Referee's order dated December 17, 1987 is affirmed. A client-paid fee is authorized, not to exceed $680.50.

SAMIE J. MOORE, Claimant
Kenneth D. Peterson, Claimant's Attorney
Roberts, et al., Defense Attorneys

WCB 85-02704
June 10, 1988
Order of Remand

The insurer requests review of that portion of Referee Shebley's order that set aside its denial of surgery relating to claimant's low back. Claimant cross-requests review of that portion of the order that upheld the insurer's denial of his aggravation claim relating to his low back. With his brief, claimant submits documents which indicate that after the date of the Referee's order he underwent the surgery which was the subject of the insurer's denial. Claimant requests that the case be remanded to the Referee for the receipt of these documents. In addition, correspondence from the parties indicates that claimant died as a result of a noncompensable heart attack after the date of the Referee's order and that claimant has no surviving dependents.

Proceedings on Board review are limited to the record developed by the Referee. ORS 656.295(3) & (5). The Board may remand a case for the receipt of additional evidence if it determines that the record has been improperly, incompletely or otherwise insufficiently developed. ORS 656.295(5). The documents relating to claimant's surgery and the fact of and the circumstances surrounding claimant's death were not part of the record developed by the Referee. We conclude that claimant's surgery and his death are relevant to the issues presented on Board review and thus that the record is insufficiently developed. We therefore remand the case to the Referee for further development and reconsideration.

IT IS SO ORDERED.

GEORGE F. MORRIS, Claimant
Borneman & Rossi, Claimant's Attorneys
Roberts, et al., Defense Attorneys
Rankin, et al., Defense Attorneys

WCB 87-03440 & 87-11137
June 10, 1988
Order on Review

Reviewed by Board Members Johnson and Crider.

Liberty Northwest Insurance Corporation requests review of that portion of Referee Myers' order that found it, rather than Industrial Indemnity, responsible for claimant's occupational disease.

ISSUE

On review, the issue is responsibility.

The Board affirms the order of the Referee.

FINDINGS OF FACT

We adopt the Referee's findings of fact as supplemented.

The medical evidence establishes that claimant's problems had a gradual onset. Claimant began experiencing periodic pain in 1985. He continued to experience periods of pain throughout 1986 which increased in duration.

While under Liberty Northwest's coverage, claimant was exposed to the same work hazards he encountered while under Industrial Indemnity's coverage.

Claimant sought and obtained medical treatment on January 5, 1987. At that time, Liberty Northwest was the insurer on the risk.

CONCLUSIONS OF LAW AND OPINION

The last injurious exposure rule assigns responsibility to the carrier on the risk at the time the condition becomes disabling. Boise Cascade Corp. v. Starbuck, 296 Or 138 (1984); Bracke v. Baza'r, 293 Or 239 (1982); Inkley v. Forest Fiber Products Co., 288 Or 337 (1980). If the claimant does not become disabled, the critical event for assigning responsibility is the date when medical treatment was first sought. Stovall v. Sally Salmon Seafood, 84 Or App 612 (1987) (rev. pending); Progress Quarries v. Vaandering, 80 Or App 160 (1986). In the present case, we look to the time claimant sought treatment in order to assign responsibility.

Liberty Northwest contends that claimant "sought" treatment in December 1986 when he made an appointment to see a physician for the first time. Industrial Indemnity was on the risk during this period. Liberty Northwest argues that the law does not equate "seeking" treatment with "receiving" treatment. Industrial Indemnity contends that claimant first sought treatment on January 5, 1987, the date when he was first examined for his complaints.

The Referee reasoned that although claimant worked only a few days under Liberty Northwest's coverage, before his first medical examination, he engaged in work that exposed him to the same type of work hazards that he encountered while working under Industrial Indemnity's coverage. Furthermore, he reasoned that liability is assigned when claimant first obtained medical treatment. We agree.

In SAIF v. Carey, 63 Or App 68 (1983), the court stated, citing Bracke v. Baza'r, supra, that the most logical triggering event in the case of a nondisabling injury or disease is the date when medical treatment is first sought. However, the court further stated that the date that a claimant first seeks medical treatment is usually not documented. Instead, the date a claimant is first examined by a physician is the date that is documented. In the present case, therefore, claimant sought medical treatment in January 1987, when he was first examined by a physician. At that time, Liberty Northwest was the insurer on the risk. Consequently, we affirm the order of the Referee.

ORDER

The Referee's order dated December 24, 1987 is affirmed.

ABRAHAM W. RING, Claimant
Dennis O'Malley, Claimant's Attorney
Rankin, et al., Defense Attorneys

WCB 85-03629
June 10, 1988
Order on Remand (Remanding)

This matter is before the Board on remand from the Court of Appeals. Ring v. Paper Distribution Services, Inc., 90 Or App 148 (1988). The court reversed the Board's order that approved of the Referee's dismissal of claimant's hearing request concerning the self-insured employer's denial of his back injury claim.

The court has found that the Referee was without authority to dismiss the proceedings because of claimant's alleged refusal to cooperate in an independent medical examination. Instead, the court has concluded that the Referee should address the questions of whether: (1) claimant's alleged refusal caused an unjustified delay in prosecution which would warrant dismissal of the claim; (2) the claim was timely filed; and (3) the claim is compensable. Consequently, we have been instructed to "reinstate the proceeding."

Accordingly, this matter is remanded to Referee Leahy for further action consistent with the court's instructions and this order.

IT IS SO ORDERED.

WILLIAM D. THOMAS, Claimant
Pozzi, et al., Claimant's Attorneys
John Motley (SAIF), Defense Attorney

WCB 86-12643
June 10, 1988
Order on Review

Reviewed by Board Members Crider and Johnson.

The SAIF Corporation requests review of that portion of Referee St. Martin's order that set aside it's denial of claimant's aggravation claim for his current low back condition. We affirm.

ISSUE

Whether claimant's off-the-job injury constituted an aggravation of his November 30, 1983 industrial injury.

FINDINGS OF FACT

Claimant compensably injured his low back on November 30, 1983, while assisting a coworker carry a 200-pound floor buffer down stairs.

Shortly thereafter, he treated with Dr. Johnston, chiropractor, who diagnosed acute bilateral lumbosacral strain Dr. Johnston found claimant's injury to be fairly severe with chronic residues but resulting in minimal impairment. Due to the nature of claimant's injury, Dr. Johnston opined claimant would need continued palliative care for maintenance and prevention of further degeneration. Claimant returned to work on December 20, 1983 and was deemed medically stationary on February 13, 1984. He continued to treat with Dr. Johnston on an "as needed" basis.

On February 4, 1985, Dr. Duff, orthopedist, performed an independent examination. Dr. Duff diagnosed lumbosacral strain, chronic and recurrent, with no permanent impairment.

The claim was closed by a February 27, 1985 Determination Order. Claimant was awarded temporary disability, but did not receive an award for permanent disability.

On May 20, 1986, claimant, his girlfriend, and parents were shooting baskets at a campground. While shooting, claimant's girlfriend bumped his hip. Experiencing immediate back pain, claimant fell to the ground. He could not get up. After some time, he was able to move to an adjacent grassy area where he laid down.

That night he was transported by ambulance to obtain emergency treatment. He was treated with pain medications and sent home. Later that morning, claimant was admitted to the hospital by Drs. Erickson and Burke for treatment of his low back.

Claimant reported on admission his prior history of back injury. He told Dr. Erickson his pain was similar but more excruciating than his previous injury. He had felt nearly fully recovered with the exception of occasional back pains. Claimant also reported he was quite athletic.

After one week of in-patient treatment, claimant was released from the hospital. Dr. Erickson diagnosed acute low back pain from lumbosacral strain, and somatic dysfunction, Ileus.

On August 20, 1986, Claimant filed an aggravation claim. SAIF denied on the basis of a new injury resulting from the off-the-job basketball incident.

On September 27, 1986, claimant was readmitted to the hospital. This episode was precipitated by claimant bending over to adjust the corner of a rug. Diagnosing an acute lumbosacral strain, Dr. Erickson attributed claimant's condition to his compensable injury.

On April 13, 1987, Dr. Nelson, orthopedist, performed an independent medical examination. Dr. Nelson traced claimant's right leg pain to the onset of back pain from his industrial injury.

We find that claimant's compensable injury is a material contributing cause of his current low back condition. We further find that claimant's compensable condition has worsened since the last award of compensation.

CONCLUSIONS OF LAW

In order to prevail on his aggravation claim, claimant must show by a preponderance of the evidence that his compensable injury was a material contributing cause of his worsened condition. ORS 656.273(1); Grable v. Weyerhaeuser, 293 Or 387, 401 (1981). If the compensable injury was such a cause, the condition is compensable as an aggravation, even if something else precipitated it. Taaffe v SAIF, 77 Or App 492 (1986). Further, claimant's compensable injury does not have to be the only cause of his worsened condition. Manous v Argonaut Insurance Co., 79 Or App 645, 649 (1986).

SAIF argues that claimant failed to establish a

compensable aggravation claim because he did not establish by a preponderance of the evidence that his 1983 industrial injury remained a material contributing cause of his condition.

SAIF relies on the lack of a medical causation report from Dr. Johnston, one of claimant's treating physicians. Dr. Johnston initially treated claimant's industrial injury and later followed him on a maintenance program.

SAIF ignores the report of Drs. Erickson, Burke, and Nelson which establish a causal relationship between the industrial injury and the May 1986 incident. Drs. Erickson and Burke treated claimant immediately after the May 25, 1986 incident and continued to treat him thereafter. In April 1987, Dr. Nelson discussed the possibility of surgery. Each physician attributes claimant's current condition to his compensable injury.

Further, SAIF argues Dr. Erickson's opinion is flawed because it is based on the doctor's mistaken impression that claimant's condition resulting from the 1983 industrial injury had not resolved. We disagree; Dr. Erickson's understanding of the claimant's medical history was correct.

Since his 1983 compensable injury, claimant has experienced recurrent low back pain for which he has continued to receive periodic treatments from Dr. Johnston. In fact, claimant treated with Dr. Johnston twice in the month preceding the May 25, 1986 basketball incident.

Claimant has received chiropractic treatment on a biannual basis prior to his 1983 compensable injury. However, he did not suffer a back injury before the 1983 injury. He stated his back pain in May of 1986 was located in the same area as his industrial injury but was a lot worse.

Additionally, prior to his injury in 1983 he actively participated in snow skiing, tennis, swimming, water skiing, woodcutting, volleyball, and driveway basketball. He was forced to cut down on these activities due to his back. In addition, he quit snow and water skiing entirely.

Claimant reported to Drs. Erickson and Burke on his May 25, 1986 admission to Eastmoreland Hospital, that the pain he was experiencing was similar but more excruciating than his previous injury. The medical reports of May 25, 1986 indicate claimant provided a truthful and sufficient history regarding his previous medical treatment of his low back.

Likewise, Dr. Nelson's medical report clearly articulates claimant's previous industrial injury and intervening periods of treatment due to episodes of continual low back pain. The record contains numerous examples of claimant's forthright history and continual episodes of pain and treatment due to his 1983 industrial injury. Nowhere in the record is there evidence of claimant's industrial injury completely resolving, with the exception of Dr. Duff's reports, and an unauthored intern admit note.

Dr. Duff opined that claimant's compensable back injury had completely resolved prior to the basketball incident. He suggested that it is common for sports injuries, such as claimant's basketball incident, to cause lumbar disc damage.

Claimant testified he continually had recurrent pain episodes and treated with Dr. Johnston to control the pain. In fact, claimant treated with Dr. Johnston on April 28, 1986 and May 5, 1986, before his May 25, 1986 injury. Further, Dr. Johnston repeatedly reported claimant's need for ongoing maintenance treatment for exacerbation of symptoms.

Claimant's history to Dr. Erickson, or any of the other physicians who examined him, was not inaccurate or incomplete. More specifically, Dr. Erickson's report of May 25, 1986 states, "The patient has a history of injuring his back about three years ago when he fell at work down some stairs. He says that this pain he has today is similar but more excruciation than that injury. He was treated by a chiropractor and is currently on a "maintenance" chiropractic regimen seeing his chiropractor every 9 weeks or so. He has been until this incident nearly fully recovered having only occasionally back pains. . . ." (Emphasis added). Dr. Nelson traced claimant's right leg pain directly back to his industrial injury. He recognized claimant's pain free periods as well as his continual and frequent intervals of back and leg pain.

SAIF cites Miller v. Granite Construction Co., 28 Or 473, 559 (1977) in support of its argument that Dr. Erickson's opinion is flawed because it is based on the mistaken impression that claimant's condition resulting from the 1983 industrial injury had not resolved and, therefore, that the persuasive impact of this opinion should be decreased.

The Referee did not explicitly rule on claimant's credibility. However, he made no finding that claimant's testimony was less than credible. An assumption can be made from the nature of the order entered that the Referee believed claimant's testimony. Hedlund v. SAIF, 55 Or App 317 (1981); Locke v. SAIF, 21 Or App 725, 726 (1975). The Referee in Miller found the claimant to be an unbelievable witness. The same result is not found here.

Further, the Referee found Dr. Erickson's conclusion that claimant's ongoing back problems are casually related to the 1983 industrial accident to be persuasive. On the other hand, he found Dr. Duff underestimated the severity of the industrial accident of 1983, the physical limitations imposed on claimant as a result therefrom, and overestimated the physical contact claimant had incurred during the basketball incident.

Dr. Erickson's opinion as claimant's treating physician is to be afforded greater weight than the opinion of Dr. Duff, who examined claimant only two times on behalf of SAIF. Weiland v. SAIF, 64 Or App 810 (1983). Further, when there is a dispute between medical experts, more weight will be given to the medical opinion which is both well reasoned and based on complete information. Somers v. SAIF, 77 Or App 259, 263 (1986).

Accordingly, we agree with the Referee's conclusion and find that the medical reports and claimant's testimony are persuasive that the compensable industrial injury was a material contributing cause to his worsened condition and that the worsened condition is not solely the result of an independent, intervening nonindustrial cause.

ORDER

The Referee's order dated July 8, 1987 is affirmed. Claimant's attorney is awarded an assessed fee of $400 for services on Board review, to be paid by the SAIF Corporation.

ARLO A. WEISE, Claimant
Michael Ewert, Claimant's Attorney
Garrett, et al., Defense Attorneys

WCB 86-00105
June 10, 1988
Order on Review

Reviewed by Board Members Crider and Johnson.

Claimant requests review of Referee Nichols' order which upheld the insurer's partial denial of his claim for deep-vein thrombosis in the left leg. On review, claimant submits for our consideration a medical report dated January 10, 1988, which was not in the hearing record. We interpret the submission as a request for remand. See Ramona Steckmann, 40 Van Natta 90 (1988). We affirm.

ISSUES

1. Remand for the taking of additional evidence.
2. Compensability.

FINDINGS OF FACT

Claimant sustained a compensable back strain and abdominal hernia while lifting a telephone pole at work. He was taken off work and referred to Dr. Spittel. Spittel performed a surgical repair of the hernia on June 24, 1985.

Since the accident, claimant has experienced pain and discomfort in the low back and legs. On October 13, 1985, he was admitted to the hospital for gradually worsening pain and swelling in his left calf. The diagnosis was deep-vein thrombosis.

Claimant filed a claim for deep vein thrombosis on November 12, 1985. The insurer denied the compensability of "left leg complaints, including vascular problems," on November 21, 1985.

Claimant continued to experience pain in his left testis, secondary to the compensable hernia condition. The testis was surgically removed by Dr. Skeeters, a urologist, on October 9, 1986. Claimant was discharged from the hospital on October 12, 1986. Four days later, he was re-admitted to the hospital with a suspected recurrence of acute deep-vein thrombosis, secondary to surgery. However, a venogram of the left leg revealed nothing more than chronic deep-vein occlusion.

Claimant became medically stationary on May 20, 1987 with regard to his compensable low back condition. The claim was closed by Determination Order on June 22, 1987 with an award of permanent total disability.

We do not find that claimant's left leg thrombosis was caused by the industrial injury. We further do not find that the thrombosis resulted from medical treatment for the industrial injury.

The hearing was held on November 12, 1987. The Referee

upheld the insurer's denial of claimant's left leg condition. After timely requesting review of the Referee's order, claimant submitted for our consideration a report from Dr. Skeeters, dated January 10, 1988, which outlined the doctor's rationale for re-admitting claimant to the hospital on October 16, 1986. We find that the medical report was readily obtainable at the time of hearing.

CONCLUSIONS AND OPINION

Remand

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 further evidence taking it must be clearly shown that material evidence was not obtainable with due diligence at the time of hearing. Kienow's Food Stores v. Lyster, 79 Or App 416, 420 (1986); Delfina P. Lopez, 37 Van Natta 164, 170 (1985).

After our de novo review, we are not persuaded that the record has been improperly, incompletely or otherwise insufficiently developed. Furthermore, we find that the medical report which prompted claimant's request for remand was readily obtainable at the time of hearing. In the report, Dr. Skeeters explained his rationale for hospitalizing claimant in October 1986. The report, which was not based on any newly discovered information, could have been obtained more than a year before the time of hearing. We conclude, therefore, that remand is not warranted.

Compensability

Claimant apparently advanced two alternative theories in support of compensability. First, he suggested that his left leg condition was caused by the industrial injury. Under this theory, claimant bears the burden of proving by a preponderance of the evidence that the industrial injury materially contributed to his disability and the need for medical treatment. Hutcheson v. Weyerhaeuser, 288 Or 51, 56-57 (1979); Milburn v. Weyerhaeuser Company, 88 Or App 375, 378 (1987).

Although the industrial injury in May 1985 caused claimant's legs to ache, he did not seek immediate treatment for that condition. Several months later, claimant was hospitalized for gradually worsening pain and swelling in the left leg. That condition was diagnosed as deep-vein thrombosis.

No medical evidence relates the thrombosis condition to the industrial injury. The only evidence supporting claimant's first theory is his testimony that the left leg had been aching continuously until his hospitalization for thrombosis. However, we decline to infer causation from the timing and location of the condition, particularly when the medical evidence does not support such an inference. See Allie v. SAIF, 79 Or App 284, 288 (1986); Bradshaw v. SAIF, 69 Or App 587, 589 (1984); Edwards v. SAIF, 30 Or App 21, 24, rev den 279 Or 301 (1977). Indeed, the marked increase in intensity of claimant's symptoms in October 1985 suggests that the thrombosis condition was separable from and unrelated to the industrial injury.

Resolution of this complex medical question largely turns on expert medical evidence. Uris v. Compensation Department, 247 Or 420, 426 (1967); Kassahn v. Publishers Paper Co., 76 Or App 105, 109 (1985). Given the absence of such evidence, we conclude that claimant has not sustained his burden of proving that his left leg condition was caused by the industrial injury.

Under his second theory of compensability, claimant contends that the left leg thrombosis resulted from hospitalization for the industrial injury. This theory is based on the principle that injuries sustained during activities which are a "direct and natural consequence" of the original industrial injury are injuries arising out of and in the course of employment, and are therefore compensable. Wood v. SAIF, 30 Or App 1103, 1108-09 (1977), rev den 282 Or 189 (1978). The courts have recognized that an injury resulting from medical treatment for a compensable injury is a compensable consequence of the industrial injury. Williams v. Gates, McDonald & Co., 300 Or 278 (1985); Fenton v. SAIF, 87 Or App 78, 81 (1987); Wood v. SAIF, supra.

Here, claimant contends that the thrombosis resulted from inactivity during and after the hernia surgery in June 1985. However, this contention is not supported by the medical evidence. Dr. Johnson, claimant's attending physician during his hospitalization for thrombosis in October 1985, could not determine whether the thrombosis was related to decreased activity. Johnson noted that claimant "continued to be up and about a fair amount."

After the insurer denied the compensability of the thrombosis, Dr. Krisciunas, claimant's family physician, wrote: "... I am unsure myself that the deep vein thrombophlebitis could not be subsequent to [hernia] surgery." That statement is of no probative value.

Given the lack of expert medical evidence relating the left leg thrombosis to medical treatment for the industrial injury, we conclude that the thrombosis was not a compensable consequence of that injury. See Uris v. Compensation Department, supra; Kassahn v. Publishers Paper Co., supra.

Finally, claimant contends that his hospitalization in October 1986 for left leg pain was a compensable consequence of surgery to remove his left testis. He relies on Dr. Skeeters' statement that he was re-admitted to the hospital on October 16, 1986 "because of questions arising in the postoperative period directly related to his surgical procedure preceding that." Claimant argues that his re-admission was a compensable postoperative procedure. That argument is not supported by the record.

Dr. Skeeters re-admitted claimant to the hospital because he suspected a recurrence of acute deep-vein thrombosis, secondary to surgery. A venogram subsequently revealed chronic deep-vein occlusion, but nothing of an acute nature. Dr. Skeeters later denied a relationship between the surgery and subsequent hospitalization, stating that claimant "would have been hospitalized regardless of surgery." Claimant has failed to sustain his burden of proving that the thrombosis condition and

hospitalizations resulting from that condition were compensable consequences of his industrial injury. We further conclude that the insurer's denial of that condition was reasonable.

ORDER

The Referee's order dated December 10, 1987 is affirmed.

GREGORY K. WILLIAMS, Claimant
Velure & Yates, Claimant's Attorneys
Phillip Nyburg, Defense Attorney

WCB 86-17641
June 10, 1988
Order on Review

Reviewed by Board Members Ferris and Crider.

Claimant requests review of those portions of Referee Mongrain's order that: (1) affirmed a previous Determination Order which awarded 10 percent (32 degrees) unscheduled permanent partial disability for his low back condition; and (2) declined to assess a penalty for the insurer's alleged unreasonable failure to pay for medical services. In its brief, the insurer contends that claimant was not entitled to an attorney fee for prevailing on a "nonexistent" denial. The issues on review are extent and penalties and attorney fees.

We affirm that portion of the Referee's order which declined to award additional permanent disability and awarded an attorney fee for prevailing against the insurer's "de facto" denial. We reverse, however, that portion which declined to assess a penalty.

FINDINGS

In March 1986, claimant sustained a compensable low back injury while driving a truck. Claimant began treating with Dr. Stockwell, chiropractor, who diagnosed a low back strain superimposed on degenerative disc disease with a small L4-4 disc herniation. She provided regular treatment for several months, forwarding bills to the insurer on a regular basis. On October 7, 1986, Dr. Stockwell explained the reason for claimant's frequent treatments between June and September. Dr. Stockwell opined that the severity of claimant's initial injury and the persistence of his symptoms required frequent treatment.

The insurer neither paid for these treatments nor issued a denial. In January 1987, claimant requested a hearing, asserting penalties and attorney fees for the insurer's failure to pay medical bills. We find the insurer's conduct unreasonable.

CONCLUSIONS

The Referee concluded that claimant's chiropractic treatments in excess of the guidelines were reasonable as Dr. Stockwell had explained and because there was no contradictory medical evidence. Therefore, he assessed an attorney fee for setting aside the insurer's "de facto" denial.

The Referee did not, however, consider the "de facto" denial unreasonable and therefore, did not assess a penalty. He did not address the lateness of the insurer's actions. Instead, the Referee relied on OAR 436-10-040(2)(a), which provides that the usual range of the utilization of medical services does not exceed two visits per month after the initial 60 days. This rule

does not constitute an arbitrary limitation of services. Rather, it is a guideline to be used concerning requirements of accountability for the services provided. Kemp v. Workers' Compensation Department, 65 Or App 659 (1983) modified on other grounds, 67 Or App 270, rev den 297 Or 227 (1984).

We disagree with the Referee's analysis. Here, claimant's chiropractor submitted an insurer-requested report of treatments on October 7, 1986. The insurer neither denied nor paid the bills within the proper 60-day period. ORS 656.262(6). Its failure to do so without justification is unreasonable. Consequently, a penalty, as well as an attorney fee is appropriate. See ORS 656.262(10); Billy J. Eubanks, 35 Van Natta 135 (1983).

The insurer contends that there is no indication of when it received Dr. Stockwell's bills. We disagree. Documents in the record show that statements of Dr. Stockwell's services were submitted to the insurer on July 1, August 1, and September 2, 1986. Although there is no indication when the insurer received these bills, we are persuaded that it was aware of these services because it requested a report from Dr. Stockwell concerning the treatments in time for her to respond by October 7, 1986. Furthermore, by the time of claimant's January 1987 hearing request, no denial had been forthcoming.

After review of the statement of services and attorney retainer agreement submitted by claimant's counsel and considering the factors set forth in OAR 438-15-010(6) a reasonable attorney fee is awarded.

ORDER

The Referee's order dated July 2, 1987 is affirmed in part and reversed in part. That portion of the Referee's order that declined to assess a penalty for the insurer's "de facto" denial of medical services is reversed. The insurer is assessed a 25 percent penalty based on the outstanding medical bills due on the date of claimant's hearing request concerning the "de facto" denial. For services rendered concerning the penalty issue, claimant's attorney is awarded $400, to be paid by the insurer. The remainder of the Referee's order is affirmed.

GREGORY D. BOEHLAND, Claimant
W.D. Bates, Claimant's Attorney
Rankin, et al., Defense Attorneys
Nancy Meserow, Defense Attorney

WCB 87-08237 & 87-07488
June 16, 1988
Order of Dismissal

Claimant requested Board review of Referee Myers' Order Approving Stipulation. Claimant has now withdrawn his request for review.

Accordingly, the request for review is dismissed and the Referee's order is final by operation of law.

The self-insured employer's counsel is authorized to charge a client-paid fee not to exceed $46.50. In so doing, we note that all attorney fees are subject to Board approval. OAR 438-15-001. However, costs incurred by an attorney in pursuing a matter on behalf of a party are not included in fees paid to any attorney. OAR 438-15-005(7). Therefore, Board approval for reimbursement of costs

incurred by the attorney is not required. See OAR 438-15-005(4), (5), (7); OAR 438-15-010(5); Janelle I. Neal, 40 Van Natta 359 (April 21, 1988).

IT IS SO ORDERED.

GALE E. COEN, Claimant
Glenn, et al., Claimant's Attorneys
Richard Barber (SAIF), Defense Attorney

WCB 87-06839
June 16, 1988
Order on Review

Reviewed by Board Members Crider and Ferris.

Claimant requests review of Referee Myers' order that affirmed a Determination Order that awarded 30 percent (96 degrees) unscheduled permanent disability for a low back injury. On review, claimant contends that he is entitled to permanent total disability or, in the alternative, an award of unscheduled permanent partial disability greater than the 30 percent granted by Determination Order. We affirm.

ISSUE

1. Whether claimant is permanently and totally disabled.

a) Whether claimant's preexisting heart condition should be considered when rating the extent of his permanent disability.

2. If claimant's preexisting heart condition should not be considered when rating the extent of his permanent disability, whether claimant is entitled to increased permanent disability due to his low back condition.

FINDINGS OF FACT

Claimant, 59 years of age, compensably injured his low back on July 9, 1985 while lifting boards and blocks. He worked approximately 20 years for his employer, performing duties which involved carpentry and concrete. Claimant possessed an eighth grade education. He was able to read the want ads for employment as well as the names of his medications.

As a result of the compensable injury, claimant sustained a lumbar sprain which aggravated his preexisting degenerative disc disease of the lumbosacral spine. On August 23, 1985, claimant sought medical treatment from Dr. Karmy, orthopedic surgeon, for his disabling low back condition. Claimant returned to work on October 16, 1985 with a 50 pound lifting limit. Three days later, he suffered a myocardial infarction.

Prior to claimant's compensable injury, he suffered from a nondisabling, heart condition. Although the coronary condition became disabling subsequent to the compensable injury, the injury neither materially caused nor worsened his preexisting coronary condition.

On November 22, 1985, the SAIF Corporation denied responsibility for any treatment or disability relating to claimant's coronary artery disease. Claimant did not appeal that denial.

On August 4, 1986, claimant again returned to modified work. However, on October 8, 1986, a flare-up of low back symptoms forced him to stop.

On April 1, 1987, a Determination Order awarded claimant 30 percent unscheduled permanent partial disability.

On April 19, 1987, Dr. Karmy approved of claimant's return to modified work. However, on April 24, 1987, claimant suffered a second heart attack which required hospitalization. This cardiac condition subsequently prevented claimant from returning to even modified work.

Claimant suffered only a slight to mild amount of impairment due to the compensable lumbar strain and aggravation of his degenerative disc disease.

At hearing, surveillance tapes refuted claimant's testimony. Therefore, we agree with the Referee that claimant is not credible and we do not rely on his testimony.

CONCLUSIONS OF LAW

The Referee concluded that there was no credible evidence indicating claimant was more disabled than the 30 percent unscheduled disability awarded by Determination Order. We agree.

Whether claimant is permanently and totally disabled.

Whether claimant's preexisting heart condition should be considered when rating the extent of his permanent disability.

ORS 656.206(1)(a) states that "[p]ermanent 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. . ." (Emphasis added).

ORS 656.214(5) provides that:

> "[t]he criteria for rating of disability shall be the permanent loss of earning capacity due to the compensable injury. Earning capacity is the ability to obtain and hold gainful employment in the broad field of general occupations, taking into consideration such factors as age, education, impairment and adaptability to perform a given job."

The legislature's failure to specify that permanent partial disability determinations may not include consideration of preexisting conditions or diseases does not justify a negative implication that it intended to exclude consideration of a preexisting condition when the worker sustains an industrial injury resulting in permanent partial disability. Barrett v. D & H Drywall, 300 Or 325, 330 (1985).

Therefore, we must determine claimant's extent of disability, measured by loss of earning capacity, caused by the

industrial accident of July 9, 1985, taking into consideration claimant's loss of earning capacity, if any, resulting from symptoms caused by the injury. Id. at 331.

There is no evidence, either medical or lay, which indicates that claimant's heart condition was disabling prior to his compensable low back condition. Although we consider all of claimant's medical impairment, including preexisting noncompensable disability, in determining whether claimant is permanently and totally disabled, a preexisting nondisabling condition need not be considered. Weyerhaeuser Co. v. Rees, 85 Or App 325 (1987).

Claimant testified to shortness of breath on occasion prior to the compensable low back condition. This was not disabling. Therefore, claimant's preexisting heart condition should not be considered when rating the extent of his permanent disability.

a) If claimant's preexisting heart condition should not be considered when rating the extent of claimant's permanent disability, whether claimant is entitled to increased permanent disability for his low back condition.

In rating the extent of claimant's unscheduled permanent disability, we must consider his loss of earning capacity and physical impairment attributable to the compensable injury, along with all of the relevant social and vocational factors set forth in OAR 436-30-380 et seq. We apply these rules as guidelines, not as restrictive mechanical formulas. Harwell v. Argonaut Insurance Co., 296 Or 505, 510 (1984); Fraijo v. Fred N. Bay News Co., 59 Or App 260 (1982).

Following our review of claimant's own discredited testimony, as well as the medical evidence concerning claimant's compensable condition, and considering claimant's physical impairment, age, limited education and work experience, and decreased adaptability to lighter occupations, we conclude that an award of 30 percent unscheduled permanent disability appropriately compensates claimant for his compensable injury.

ORDER

The Referee's order dated October 20, 1987 is affirmed.

DAVID C. FLINT, Claimant
Royce, et al., Claimant's Attorneys
Thomas Sheridan (SAIF), Defense Attorney

WCB 86-08398
June 16, 1988
Order on Review

Reviewed by Board Members Crider and Johnson.

Claimant requests review of Referee St. Martin's order which upheld the SAIF Corporation's denials of claimant's occupational disease claim for chemical poisoning. We affirm.

ISSUE

Whether claimant's workplace chemical exposure was the major contributing cause of his physical and psychological conditions.

FINDINGS OF FACT

Claimant, 33 years old, was employed by SAIF's insured as a chemical applicator from September 1979 to February 1985. Beginning in March of each year, claimant was in the field an average of 10 days per month. While in the field, he was exposed to more than 20 different herbicides, insecticides, fungicides and growth regulators in both granular and liquid forms. Much of the exposure, however, came from the liquid herbicides 2,4-D, Trimec, Weedone and Roundup. Skin contact with the chemicals was unavoidable. It frequently soaked claimant's clothes and covered his hands and feet. He also inhaled the chemical mist.

A certain class of organophosphates, including some of the above listed herbicides, cause peripheral neuropathy in a proportion of those people who use them. Peripheral neuropathy refers to the nerves that travel through the arms and legs. One characteristic of organophosphate exposure is a sensory motor neuropathy.

In the fall of 1984 claimant began to exhibit a plethora of symptoms. They included: sensitivity to sound, throbbing headaches, blurred vision, pain and numbness of the hands, some lower extremity numbness, lack of coordination, anterior chest pain, hot and cold sweats (nocturnal), bloodshot eyes, oozing blood from the nose and mouth, red skin lesions, swelling of the axillae and throat, enlarged lymph nodes, constipation and diarrhea, blood in his stool, frequent urination, impotence, poor appetite, general malaise, memory loss, irritability, tension, paranoia and violent behavior.

Claimant became increasingly volatile from September 1984 until January 1985. He left his employment in February 1985. His symptoms continued to worsen until May 1985, at which time they began to diminish. Currently, when claimant is exposed to certain chemicals, weakness, nausea and headaches recur.

Prior to claimant's employment with SAIF's insured, claimant had a medical history of dermatitis, hypertension, a bleeding disorder (from the nose and ears), a syncopal (blackout) episode and pneumonia.

On April 22, 1985, SAIF denied claimant's claim but subsequently entered into a stipulated agreement to reconsider this denial. On June 2, 1986, SAIF again denied claimant's occupational disease claim.

Neuropsychological testing performed in March 1985 raised serious doubts concerning the validity of the results. There was strong evidence of a neurotic disorder and low motivation to perform well. There was no evidence of organic brain damage.

95 percent of all organophosphate material is excreted from the body within 72 hours of exposure. A urine test was performed in May 1985, approximately three months following claimant's last chemical exposure. The sample exhibited such a high concentration of 2,4-D that the February 1985 exposure level consistent with known excretion rates, would have caused certain death. Therefore, some further exposure following the employment exposure was indicated.

Claimant's expansive symptom complex coupled with the neuropsychological testing and immunological studies were not compatible with any physical or psychological damage resulting from chemical exposure. Instead, his condition indicated a somatization disorder with mixed disturbance of emotions, paranoid ideation, and phobic reactions. A secondary diagnosis included a chronic hyperventilation syndrome.

A somatization disorder refers to that condition whereby an individual channels emotional upsets into physical symptoms. Frequently, these physical symptoms are accompanied by paranoia and phobic reactions.

The record does not indicate that the chemical work exposure was the major contributing cause of claimant's physical and psychological problems. The record indicates that claimant suffered from a somatization disorder. The evidence is insufficient to establish that the disorder was caused or worsened by any workplace chemical exposure.

CONCLUSIONS OF LAW

Based upon the totality of the evidence, the Referee was unable to conclude that claimant had met his burden of proof. Although he found that the lay testimony supported the dangerous nature of the chemicals, the medical evidence did not establish a causal connection between the exposure and claimant's condition.

To establish a compensable occupational disease, claimant must prove that his work activities were the major contributing cause of either the onset or worsening of his disease. See ORS 656.802(1)(a); Dethlefs v. Hyster Co., 295 Or 298, 310 (1983); Blakely v. SAIF, 89 Or App 653, 656 (1988). "Major contributing cause" means a cause or combination of causes which contributed more to the onset or worsening than all other causes combined. See McGarrah v. SAIF, 296 Or 145, 166 (1983); Dethlefs v. Hyster Co., supra, 295 Or at 309-310; Clark v. Erdman Meat Packing, 88 Or App 1, 5 (1987).

In March 1985, Drs. Crossen and Weins, psychologists, reported that discrepancies in claimant's neuropsychological testing raised serious doubts about the validity of his performance. Furthermore, test results revealed low motivation to perform as well as possible. While the psychologists acknowledged the possibility of physical damage due to chemical exposure, in the presence of serious questions concerning motivation and strong evidence suggesting a neurotic disorder, they diagnosed a somatization disorder.

In February 1985, Dr. Dietz examined claimant. He could not state whether or not claimant had sustained damage from pesticides.

In April 1985, Dr. Buscher, clinical ecologist, examined claimant. He reported that, in all probability, claimant had been injured by pesticide exposure.

In June 1985, Dr. Ginsberg, electrophysiological diagnostician, conducted "somatosensory evoked response" tests which returned normal.

In July 1985, Dr. Bardana, immunologist, examined claimant and found no toxic effect from claimant's work exposures. He diagnosed somatiform disorder with chronic anxiety attacks. The multiplicity of complaints also supported chronic hyperventilation syndrome.

In August 1985, Dr. Morton, a professor of environmental medicine at the Oregon Health Sciences University, examined claimant and found that his symptoms did not correspond with a workplace chemical exposure. Although blood and urine tests for 2,4-D were positive, Dr. Morton considered them to be at impossibly high levels three months post-exposure and concluded that they must have been due to exposures other than those at claimant's workplace.

In May 1986, Dr. Shearer, a consultant in genetic toxicology, reviewed claimant's medical records and concluded that his health problems were related to chemical poisoning of his nervous system. Dr. Shearer hypothesized that the high level of 2,4-D in claimant's urine was due to chronic exposure to pesticides.

In June 1986, Dr. Buscher reported that claimant's health problems seemed to be related to his work exposure.

In September 1986, Dr. Bardana submitted a supplemental report to his August 1985 report. After reviewing the additional medical information, he was convinced that claimant was so personally invested in his obsession regarding pesticide intoxication that he consciously attempted to distort or manipulate the specific data base. Dr. Bardana found no reason to suspect any toxic effect from claimant's work exposure.

Drs. Bardana and Morton testified at hearing to the effect that claimant's chemical work exposure neither caused nor worsened his symptom complex. Both doctors voiced well-reasoned opinions. We find their opinions most persuasive.

After conducting our de novo review of the medical and lay evidence, we conclude that claimant failed to prove that the major contributing cause of his physical and psychological conditions was his chemical work exposure.

ORDER

The Referee's July 9, 1987 order is affirmed.

JEFFREY L. FRANCIS, Claimant
Hayner, et al., Claimant's Attorneys
Foss, et al., Defense Attorneys

WCB 86-12078
June 16, 1988
Order on Review

Reviewed by Board Members Ferris and Crider.

The self-insured employer requests review of that portion of Referee Gruber's order that increased claimant's unscheduled permanent disability award for a low back injury from 15 percent (48 degrees), as awarded by a Determination Order, to 30 percent (96 degrees). Claimant cross-requests review of that part of the Referee's order that rejected his request for additional temporary disability compensation. We affirm on both issues.

ISSUES

1. Extent of unscheduled low back disability.

2. Entitlement to additional temporary disability.

FINDINGS OF FACT

We adopt the Referee's Findings of Fact as our own. We supplement those findings as follows.

Claimant requires periodic breaks during the workday in order to perform his driving duties.

The March 21, 1986 Determination Order terminated temporary total disability benefits as of February 17, 1986.

As a result of his compensable injury, claimant suffers a permanent impairment of his low back in the mildly moderate range.

CONCLUSIONS OF LAW AND OPINION

Extent of Unscheduled Permanent Partial Disability

We affirm and adopt the Referee's conclusions and reasoning with regard to the extent of disability issue.

Temporary Total Disability

We also affirm and adopt the Referee's conclusions and reasoning with regard to the temporary disability issue. See Nick L. Ward, 34 Van Natta 1739 (1984) (claimant's treating physician failed to inform claimant that he had released him to return to work).

ORDER

The Referee's order dated May 7, 1987 is affirmed. Claimant's attorney is awarded an assessed fee of $500 for services on Board review concerning the extent of permanent disability issue, to be paid by the self-insured employer. A client-paid fee not to exceed $140 is also approved.

GARY L. GILBERT, Claimant
Pozzi, et al., Claimant's Attorneys
Moscato & Byerly, Defense Attorneys

WCB 86-14534
June 16, 1988
Order on Review

Reviewed by Board Members Crider and Ferris.

Claimant requests review of Referee Menashe's order which affirmed the Determination Order that awarded no unscheduled permanent disability for a chronic rhinitis condition. The sole issue is extent of unscheduled disability. We affirm.

FINDINGS OF FACT

Claimant, a baker, had worked approximately 10 years for the employer. In January 1984, claimant developed nasal symptoms, including congestion, pressure, pain and sneezing. The diagnosis was chronic irritant rhinitis due to exposure to fumes, dust and

other airborne particles in the work place. Surgery in July 1985 initially improved his condition, but symptoms returned after four weeks. Claimant missed about three weeks of work during his recovery from surgery.

The self-insured employer denied claimant's occupational disease claim for the rhinitis condition. In May 1986, Referee Menashe set aside the denial, finding the claim compensable.

Dr. Lipman, the treating ear, nose and throat specialist, released claimant for modified work with the restriction to avoid dust and fumes. Claimant became medically stationary on June 13, 1986. The claim was closed by Determination Order on July 21, 1986 with no permanent disability award.

At the time of hearing, claimant was working primarily as an oven man for the employer. He was working approximately seven hours per day. Approximately five of those hours were spent in actual oven work, while the rest of the shift involved scaling, mixing and rolling. Claimant was instructed by his supervisors and treating physician to wear a respiratory mask at work. However, he would not wear the mask during oven work, even though airborne particles are present in the workplace.

Claimant continued to suffer nasal congestion and pain with occasional bleeding episodes. He takes medication daily for the condition. He also experiences occasional energy loss. He has missed a few days of work due to his nasal condition. His condition improves when he takes time off from work.

We are unable to find that claimant has sustained any permanent impairment from his compensable rhinitis condition.

CONCLUSIONS AND OPINION

The criterion for rating unscheduled permanent disability is the permanent loss of earning capacity due to the compensable injury or condition. ORS 656.214(5), 656.804. In determining the loss of earning capacity, we consider, inter alia, medical and lay evidence of physical impairment resulting from the compensable injury or condition.

Here, claimant clearly suffers occupational, nasal symptoms which impair his earning capacity; however, there is insufficient evidence that the impairment is permanent. Dr. Lipman, claimant's treating physician, wrote on June 13, 1986 that claimant would continue to suffer a degree of chronic nasal congestion, but that no permanent impairment would result. Lipman later added, on October 14, 1986 that claimant could improve his condition by either wearing a respiratory mask at work or working away from dust or fumes. Claimant nevertheless refuses to wear the mask throughout his work shift, exposing himself to airborne particles.

If claimant had worn the mask as instructed and continued to suffer nasal symptoms, it would have been evident that he is unable to work around dust or fumes, reflecting a permanent impairment and loss of earning capacity. However, claimant's refusal to wear the mask precludes any such finding. Consequently, we conclude that claimant has sustained no permanent disability from his compensable rhinitis condition.

ORDER

The Referee's order dated June 19, 1987 is affirmed. The Board approves a client-paid fee not to exceed $100.

RAYMOND P. GODAIRE, Claimant
Debra Ann Kronenberg, Claimant's Attorney
Rankin, et al., Defense Attorneys

WCB 86-16907
June 16, 1988
Order on Review

Reviewed by Board Members Crider and Ferris.

The insurer requests review of Referee Mulder's order that set aside its partial denial relating to claimant's neck.

ISSUE

Whether the industrial accident of January 2, 1986 compensably worsened claimant's preexisting neck condition.

FINDINGS OF FACT

Before going to work for the employer, claimant injured his neck on three occasions. The first injury occurred in the late 1960s and resulted in the surgical fusion of C5-6. The second injury occurred in 1972 and resulted in the surgical fusion of C6-7. The third injury, a strain of the neck, occurred in 1979. This injury was treated conservatively and required no further surgery.

On January 2, 1986, claimant injured his low back, mid back and left arm while working as a cook for the employer when he lifted a heavy pan with a large turkey in it. Claimant treated initially with Dr. Freistat, an osteopath, who diagnosed a lumbar strain and prescribed conservative treatment. Claimant expressed no neck complaints to Dr. Freistat.

Claimant then transferred his care to Dr. Bachhuber, an orthopedic surgeon. Dr. Bachhuber noted pain in claimant's low back, between the shoulder blades and the left elbow area. Dr. Bachhuber provided treatment for claimant's conditions which included injections in claimant's left elbow. He diagnosed the elbow condition as bicipital tendinitis or lateral epicondylitis. Claimant expressed no neck complaints to Dr. Bachhuber. Dr. Bachhuber declared claimant medically stationary in late April 1986 and rated his impairment at zero.

On October 21, 1986, claimant began treating with Dr. Mason, a neurosurgeon, with complaints of low back and neck pain. In January 1987, the insurer issued a partial denial relating to claimant's neck condition. In April 1987, Dr. Mason opined that claimant's neck complaints were related to the turkey lifting incident. About a week later, after reviewing claimant's entire medical file and noting the absence of neck complaints after the turkey lifting incident, Dr. Mason opined that claimant had not injured his neck by lifting the turkey. He signed a statement to this effect prepared by counsel for the insurer. About a week later, in a letter to claimant's attorney, Dr. Mason reversed his opinion again, stating that the turkey lifting incident "could have aggravated the cervical discogenic pain."

The industrial accident of January 2, 1986 did not materially affect or worsen claimant's preexisting neck condition.

OPINION AND CONCLUSIONS

In order to overcome the insurer's partial denial of his neck condition, claimant has the burden of proving that the industrial accident in January 1986 was a material contributing cause of a worsening of his preexisting neck condition. Skinner v. SAIF, 66 Or App 467, 470 (1984). We conclude that claimant has failed to carry this burden for the following reasons.

First, claimant reported no neck symptoms until nine and a half months after the industrial accident. This fact indicates that the industrial accident did not affect his neck. Claimant attempted to explain the absence of neck complaints by testifying that when he complained of left arm pain, he meant pain from his neck down his left arm. We rejected this testimony in arriving at our findings of fact because we found it implausible that claimant would not have explained this to the earlier treating doctors, especially Dr. Bachhuber, who rendered specific treatment for claimant's left arm complaints.

Second, claimant's neck had been injured three times prior to the industrial injury and he had undergone surgery on two occasions. The residual effects of these injuries and surgeries, which can naturally be expected to flare-up occasionally, provide a plausible noncompensable alternative explanation for claimant's October 1986 neck complaints.

Third, Dr. Mason's opinion to the effect that the industrial accident "could have aggravated [claimant's] cervical discogenic pain" is not convincing. The phrase "could have" indicates that Dr. Mason was speculating about the causal relation between the industrial accident and the neck complaints rather than stating an opinion based upon medical probability. This impression is reinforced by the inconsistent opinions which preceded the most recent opinion.

For the above reasons, we conclude that the insurer's partial denial should be upheld.

ORDER

The Referee's order dated May 27, 1987 is reversed. The insurer's partial denial dated January 13, 1987 is reinstated and upheld. A client-paid fee of up to $105 is authorized for services on Board review.

ALVA P. HOGAN, Claimant
Olson Law Firm, Claimant's Attorney
Roberts, et al., Defense Attorneys

WCB 86-09174
June 16, 1988
Order on Review

Reviewed by Board Members Crider and Ferris.

Claimant requests review of Referee Howell's order that upheld the insurer's partial denial of claimant's current chiropractic treatment relating to her low back and right leg condition. We affirm.

ISSUES

1. Propriety of the insurer's denial of claimant's current chiropractic treatments pursuant to OAR 436-10-060(2).

2. Reasonableness and necessity of claimant's current chiropractic treatments.

FINDINGS OF FACT

Claimant, 77 years old on the date of hearing, was compensably injured on November 30, 1985 when she slipped and fell in the employer's parking lot. She received emergency treatment for what was diagnosed as a fracture of the right pelvis.

Dr. Brust, a medical doctor, assumed claimant's care. Over the next three-and-one-half months claimant improved, but she continued to complain of pelvic pain and headaches. On March 26, 1986, she first told Dr. Brust of sacroiliac discomfort. Dr. Brust found that claimant stood on either leg without assistance or difficulty, she walked without a limp, hip abduction caused no discomfort and she had a good range of low back motion. Dr. Brust anticipated that claimant could return to modified work with the employer on about April 1, 1986.

On December 28, 1985, claimant began seeing Dr. Schubert, a chiropractor, for low back and right leg pain. Dr. Schubert diagnosed sacroiliac sprain/subluxation and he treated her for that condition with manipulations and ultra sound.

Because claimant disagreed with Dr. Brust's opinion that she could return to modified work on April 1, 1986, she changed attending physicians to Dr. Heder, a medical doctor, on March 31, 1986.

On April 7, 1986, claimant was examined by BBV Medical Services. Claimant then had episodic right low back and buttock discomfort. Diagnoses were: healing fractures of the right pelvis; osteoporosis of the lumbar spine; and contusion and degenerative arthritis of the sacroiliac joints. Claimant was not considered medically stationary. Mild physical therapy was recommended.

On June 19, 1986, the insurer denied further chiropractic treatments on the basis that claimant had selected Dr. Heder as her attending physician and she could have only one attending physician at a time. The insurer also noted that Dr. Heder felt that additional chiropractic treatment was not reasonable and necessary.

Claimant continued to treat with Dr. Heder until late July 1986. On July 28, 1986, he indicated that claimant was medically stationary and that she could return to modified work being offered to her by the employer. Claimant, however, did not feel capable of returning to work. Consequently, she changed attending physicians to Dr. Knox, a neurologist.

Dr. Knox diagnosed a host of possible problems. He reported that claimant could not work. He continued to follow her to the date of hearing.

During the time claimant treated with Dr. Heder and with Dr. Knox, she continued chiropractic treatments with Dr. Schubert. On January 10, 1987, Dr. Schubert performed a "closing examination" and terminated chiropractic treatment.

Dr. Schubert's treatment provided temporary relief from

hip, pelvis, upper back and neck pain. That relief lasted a couple of days, depending upon claimant's activities. Dr. Schubert's treatments were palliative not curative. After Dr. Schubert stopped treating her, claimant occasionally experienced increased pain which she controlled with medication. Claimant had not returned to work as of the date of hearing.

CONCLUSIONS OF LAW AND OPINION

Propriety of the Denial

The Referee found that, pursuant to OAR 436-10-060(2) (formerly OAR 436-69-401(2)), Dr. Schubert's fees were not payable. The rule provides:

> "The patient may have only one attending physician at a time. Treatment by other physicians shall be at the request of the attending physician who shall promptly notify the insurer of the request. Fees for treatment by more than one physician at the same time are payable only when the medical conditions present are related to the treatment of the compensable injury or illness and are sufficiently different that separate medical skills are needed for proper treatment." (Emphasis added)

The rule has been approved by the courts. Kemp v. Workers' Comp. Dept., 65 Or App 659, 669 (1983), modified 67 Or App 270, rev den 297 Or 227 (1984).

Claimant's attending physician in this case was Dr. Brust until she changed to Dr. Heder; Dr. Heder until she changed to Dr. Knox; and Dr. Knox up to the date of hearing. None of claimant's attending physician's requested treatment of her by Dr. Schubert. Therefore, in accordance with OAR 436-10-060(2), the insurer's denial is proper.

Claimant nevertheless argues that Dr. Schubert's treatment requires separate and distinct medical skills apart from those of her treating physician and that, therefore, his treatment is compensable under the rule. We note in this regard that the question under the rule is whether claimant has "medical conditions present [that] are ... sufficiently different" so that "separate medical skills are needed for proper treatment." Claimant's argument focuses on the need for separate medical skills without noting the need to prove "different" medical conditions requirement treatment. However, we do not reach this question because of our threshold determination that claimant's attending physicians did not request treatment by Dr. Schubert.

Reasonableness and Necessity of Treatment

Claimant argues on review that the chiropractic services were reasonable and necessary. Our conclusion above concerning application of OAR 436-10-060(2) renders this question moot. We nevertheless address this issue for purposes of future review.

Claimant has the burden of proving the reasonableness and necessity of the chiropractic treatments. SAIF v. Belcher, 71

Or App 502 (1984). Dr. Schubert's treatments were palliative. When palliative treatments reduce a claimant's pain and enable her to work they are considered reasonable and necessary. West v. SAIF, 74 Or App 317, 321 (1985). However, considering claimant's continuing state of unemployment, the treatments here have not enabled her to work. Jose Ybarra, 40 Van Natta 5, 7 (1988). In addition, claimant's current attending physician, Dr. Knox, was unable to express an opinion as to the appropriateness of further chiropractic care. Further, claimant went for the three months prior to hearing without receiving chiropractic treatments. We conclude that Dr. Schubert's chiropractic treatments are not reasonable and necessary in relation to claimant's November 1985 injury.

ORDER

The Referee's order dated April 29, 1987, as amended May 1, 1987, is affirmed. A client-paid fee not to exceed $110 is approved.

DONNA J. RUSSELL, Claimant
Malagon & Moore, Claimant's Attorneys
E. Jay Perry, Defense Attorney

WCB 87-05486
June 16, 1988
Order on Review

Reviewed by Board Members Ferris and Crider.

The insurer requests review of those portions of Referee Baker's order that: (1) increased claimant's award of unscheduled permanent partial disability for her left shoulder from the 10 percent (32 degrees) granted by Determination Order to 20 percent (64 degrees); (2) included attendance bonus earnings in the computation of the rate of claimant's temporary total disability compensation; and (3) assessed penalties and attorney fees for the insurer's allegedly unreasonable calculation of the rate of claimant's temporary total disability compensation. With her respondent's brief, claimant submits an exhibit not previously introduced. We treat this submission as a request for remand. See Judy A. Britton, 37 Van Natta 1262 (1985).

ISSUES

1. Remand to allow receipt of the exhibit submitted with claimant's brief on Board review.

2. The extent of unscheduled permanent partial disability for claimant's left shoulder.

3. The correct rate of claimant's temporary total disability compensation.

4. Penalties and attorney fees for improper calculation of the rate of claimant's temporary total disability compensation.

FINDINGS OF FACT

Claimant began working for the employer in 1979 and performed a variety of jobs. During most of 1986, claimant was paid on a salary basis. As of December 1, 1986, however, the employer began paying her on an hourly basis.

On March 12, 1987, claimant sought emergency medical treatment for left shoulder pain. The emergency room physician diagnosed osteolysis of the left distal clavicle and referred claimant to Dr. Schackner, an orthopedic surgeon for treatment.

Claimant filed a claim for her condition on March 19, 1987, which was later accepted by the insurer. She left work due to her condition on March 24, 1987. Before leaving work, claimant regularly worked five days per week, eight hours per day. In addition, she worked an average of 2.36 hours per week of overtime between December 1, 1986 and March 24, 1987. Claimant also received an "attendance bonus" of $75 in her paycheck for every month in which she did not miss work due to illness, injury or other personal reason. The purpose of the bonus was to provide an incentive for workers to be at work every scheduled shift. Claimant received this bonus in December 1986 and February 1987, but did not receive it in January 1987 because she missed work due to illness or in March 1987 because she missed work due to her compensable left shoulder condition. The attendance bonus system had been in place for a considerable period before December 1986, but no evidence regarding claimant's receipt of the bonus was presented for earlier months. The insurer computed the rate of claimant's temporary total disability compensation without considering claimant's overtime hours or her receipt of attendance bonuses.

After evaluating claimant's condition, Dr. Schachner recommended that claimant undergo surgical resection of the distal end of the clavicle. Claimant rejected this treatment approach because she was afraid that the operation might not improve her condition and might worsen it.

In April 1987, claimant was examined by Dr. Filarski, an orthopedic surgeon. He recommended either cortisone injections or surgical resection of the distal end of the clavicle. In July 1987, Dr. Schachner reported that claimant had rejected cortisone injections and continued to reject surgery. Because no further curative treatment was possible in light of claimant's rejection of the modalities recommended, Dr. Schachner declared claimant medically stationary and rated her impairment as minimal.

Without cortisone or surgical treatment, claimant is limited to light work which does not involve repetitive motion above her shoulders or lifting or carrying with her arm away from her side. The claim was closed by Determination Order dated August 17, 1987 with a 10 percent unscheduled award. There is a strong probability that surgery would result in the complete resolution of claimant's symptoms and would allow her to work without limitations or restrictions.

Claimant was 34 years old at the time of the hearing, is a high school graduate and has completed two years of college. Before working for the employer, claimant had worked as an electrical parts delivery person, a short order cook, a baker and bakery store manager. The employer manufactures interior wall paneling and prefabricated fencing materials. Claimant worked on various saws and other pieces of equipment, drove trucks and forklifts and also performed quality control, training and supervisory functions.

With her respondent's brief on Board review, claimant submitted a report by clinical social worker Carol Green dated August 18, 1987. The hearing in this case was held on October 14, 1987.

OPINION AND CONCLUSIONS

Remand

The Board may remand a case to a Referee if the case has been improperly, incompletely or otherwise insufficiently developed or heard by the referee. ORS 656.295(5). The Board will only remand, however, if the evidence which is to be introduced on remand was not obtainable with due diligence before the hearing. See Bernard L. Osborn, 37 Van Natta 1054, 1055 (1985).

The exhibit submitted with claimant's respondent's brief on Board review is dated well before the hearing in this case and there is no indication that this exhibit was not obtainable with due diligence before the hearing. We conclude, therefore, that the case should not be remanded to the Referee for the receipt of the exhibit.

Extent of Disability

The criteria for rating the extent of unscheduled permanent partial disability is the permanent loss of earning capacity due to the compensable injury. ORS 656.214(5). Disability due to a claimant's unreasonable refusal to submit to recommended treatment is not considered in rating the extent of disability. Sarantis v. Sheraton Corp., 69 Or App 575, 577, petition for rev withdrawn 298 Or 151 (1984); Clemons v. Roseburg Lumber Co., 34 Or App 135, 139 (1978). In determining whether a claimant's refusal to submit to treatment is reasonable, the question is whether, if compensation were not an issue, an ordinarily prudent and reasonable person would submit to the recommended treatment based upon the claimant's present physical and psychological condition, the degree of pain accompanying and following the treatment, the risks posed by the treatment and the likelihood that it would significantly reduce the claimant's disability. Id. The employer or insurer has the burden of proving that the refusal was unreasonable. Nelson v. EBI Companies, 296 Or 246, 252 (1984); Sarantis v. Sheraton Corp., supra, 69 Or App at 577.

In the present case, claimant refused to submit to two treatment modalities recommended by Drs. Schachner and Filarski: cortisone injections and surgical resection of the distal end of the clavicle. Regarding the first modality, the record does not reflect the pain and risks, if any, associated with the injections. It also does not reflect the nature or duration of the benefit expected from this treatment. The record is similarly deficient regarding the proposed surgery, except that significant improvement was a "strong probability." The record as developed fails to provide us with sufficient information to gauge the reasonableness of claimant's refusal of the recommended treatments. This failure must be charged against the insurer as the party with the burden of proof. The extent of claimant's disability, therefore, will be rated without regard to her refusal of the recommended treatments.

In rating the extent of unscheduled permanent partial disability for claimant's left shoulder, we consider the physical impairment as reflected in the medical record and lay testimony 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).

Following our review of the medical and lay evidence, we conclude that claimant's left shoulder impairment is in the upper portion of the minimal range. Considering this impairment in light of the relevant social and vocational factors, we conclude that an award of 64 degrees for 20 percent unscheduled permanent partial disability adequately and appropriately compensates claimant for the permanent loss of earning capacity due to the compensable injury.

Rate of Temporary Total Disability Compensation

Temporary total disability compensation is computed as a percentage of a worker's "wages." ORS 656.210(1). "Wages" is defined in ORS 656.005(26) as "the money rate at which the service rendered is recompensed under the contract of hiring in force at the time of the accident, including reasonable value of board, rent, housing, lodging or similar advantage received from the employer, and includes . . . tips." Pursuant to former ORS 656.210(2), the Director promulgated rules effective at the time of claimant's injury for determining the wages of workers "whose remuneration is not based solely upon daily or weekly wages." Former OAR 436-60-020(4).

The insurer did not consider claimant's overtime hours or attendance bonus in computing the rate of her temporary total disability compensation. Claimant's overtime hours clearly should have been considered pursuant to former OAR 436-60-020(4)(i). The insurer conceded as much at the hearing and does not argue to the contrary on Board review.

As for attendance bonuses, they were contemplated by the contract of employment between claimant and the employer and when claimant qualified for a bonus during a given month, her remuneration for that month was increased. During those months, therefore, the attendance bonus was one component of the "money rate at which the service rendered [was] recompensed under the contract of hiring in force at the time of the injury" and hence qualified as "wages" within the meaning of ORS 656.005(26) and ORS 656.210(1).

The fact that claimant did not always qualify for the attendance bonus does not change this conclusion. It simply raises a question concerning how claimant's irregular receipt of the bonuses should be computed into her wage rate for purposes of temporary total disability compensation. This question is answered by former OAR 436-60-020(4)(j), which relates to workers "[e]employed with incentive pay." Under that rule, the wages received by claimant as attendance bonuses between December 1, 1986 and March 24, 1987 should have been averaged according to the formula set forth in former OAR 436-60-020(4)(a) and then added to her regular weekly wage and her average weekly overtime wage to arrive at her total weekly wage. The total weekly wage should have then been used as the basis for the insurer's computation of claimant's temporary total disability compensation.

Penalties and Attorney Fees

Claimant is entitled to a penalty of up to 25 percent of compensation not timely paid and an associated attorney fee if the insurer's delay in paying the compensation was unreasonable. ORS 656.262(10); 656.382(1). "Unreasonable resistance" within the meaning of ORS 656.382(1) includes situations where an insurer is clearly obligated to pay compensation but defers doing so without good cause. Williams v. SAIF, 31 Or App 1301, 1306-07 (1977). Attorney fees may be awarded under ORS 656.386(1) regardless of which party initiated the hearing on the issue. Id. at 1306 n.1; see Gray v. SAIF, 70 Or App 313, 315-16 n.3 (1984).

The insurer improperly calculated claimant's temporary disability compensation rate by not including her overtime pay or attendance bonuses in the calculation. This miscalculation resulted in a delay in payment of compensation. The insurer has offered no explanation for its failure to include claimant's overtime pay in its calculation. That failure, therefore, was unreasonable. Lester v. Weyerhaeuser Co., 70 Or App 307, 311-12, rev den 298 Or 427 (1984).

Regarding its failure to include the attendance bonuses, the insurer contends that the status of such bonuses as wages was so unclear under the law that it had a legitimate doubt regarding its duty to include them in its calculation. We reject this argument. The attendance bonuses readily satisfied all of the elements of ORS 656.005(26) and were contemplated by former OAR 436-60-020(4)(j). The status of attendance bonuses as wages, therefore, was not so unclear as to give rise to a legitimate doubt.

We conclude that a penalty of 25 percent of all of the temporary total disability compensation not timely paid along with an attorney fee of $400 is appropriate under these circumstances.

ORDER

The Referee's order dated December 3, 1987 is affirmed as supplemented. Claimant's attorney is awarded a fee of $950 for services on Board review on the permanent and temporary disability issues, to be paid by the insurer. Counsel for the insurer is authorized to bill a client-paid fee of up to $1,126.50 for services on Board review.

MIKE WHIPPLE, Claimant
Doblie & Associates, Claimant's Attorneys
Schwabe, et al., Defense Attorneys

WCB 86-06166
June 16, 1988
Order on Review

Reviewed by Board Members Ferris and Crider.

The insurer requests review of Referee St. Martin's order that set aside its denial of claimant's aggravation claim relating to his lungs.

ISSUES

(1) Whether claimant proved an aggravation of his compensable lung condition in April 1986.

(2) Whether claimant proved that his compensable lung condition required medical services in April 1986.

FINDINGS OF FACT

Claimant filed a claim in June 1984 for asthma due to isocyanate exposure. The claim was accepted and was closed by Determination Order in November 1984 with no award of permanent partial disability. A July 1985 stipulation granted claimant a 5 percent unscheduled award.

In April 1986, claimant contracted pneumonia and experienced an associated flare-up of asthma. Claimant sought emergency medical treatment with complaints of general malaise, chills, fever, coughing, shortness of breath and chest pain. The emergency room physician prescribed antibiotics for the pneumonia and bronchodilator medication for the asthma. Claimant's condition was subsequently followed by Dr. Keppel, a pulmonary specialist. Dr. Keppel prescribed additional medication for the asthma condition. There is no evidence that claimant missed time from work or that he was otherwise incapacitated from performing work in the broad field of general occupations during his bout with pneumonia and the associated asthma flare-up.

Pneumonia is a bacterial infection of the lungs. A person with asthma is not at increased risk of contracting pneumonia.

OPINION AND CONCLUSIONS

Aggravation

To establish an aggravation under ORS 656.273(1), a claimant must prove a worsening of his condition and a causal relation between the worsening and a compensable injury or disease. Van Horn v. Jerry Jerzel, Inc., 66 Or App 457, 459, rev den 297 Or 82 (1984); Anderson v. West Union Village Square, 43 Or App 295, 297, modified on other grounds, 44 Or App 685 (1980). To prove a worsening, a claimant must show a change in his condition since the last arrangement of compensation which entitles him to additional temporary or permanent disability compensation. Smith v. SAIF, 302 Or 396, 399-401 (1986); see also Gwynn v. SAIF, 304 Or 345, 352-53 (1987). To prove a causal relation between the worsening and a compensable injury or disease, the claimant must show that the compensable injury or disease was a material contributing cause of the worsened condition. Grable v. Weyerhaeuser Co., 291 Or 387, 400-01 (1981).

Although claimant proved a change in his condition by showing that he contracted pneumonia and experienced a flare-up of asthma, he failed to prove that he lost any time from work or that he was otherwise incapacitated from performing work in the broad field of general occupations. He thus failed to prove entitlement to additional temporary or permanent disability as a result of the change in his condition and, under the rule of Smith v. SAIF, supra, failed to prove a worsening of his condition within the meaning of ORS 656.273(1). The insurer's aggravation denial, therefore, was correct and shall be reinstated.

Medical Services

To establish entitlement to compensation for medical services under ORS 656.245(1), a claimant must prove the reasonableness and necessity of the medical services and a causal

relation between the medical services and a compensable injury or disease. Jordan v. SAIF, 86 Or App 29, 32 (1987); West v. SAIF, 74 Or App 317, 320 (1985). To prove the reasonableness and necessity of rendered medical services, a claimant must show that at the time the services were rendered they were likely to be of significant curative, palliative, preventive or restorative benefit. Id. at 320-21; Michael D. Barlow, 38 Van Natta 196, 197-98 (1986). To prove a causal relation between the medical services and a compensable injury or disease, a claimant must show that the compensable injury or disease was a material contributing cause of the need for the services. Van Blokland v. Oregon Health Sciences University, 87 Or App 694, 697-98 (1987); Jordan v. SAIF, supra, 86 Or App at 32. Material contributing cause means a substantial cause, but not necessarily the sole cause or even the most significant cause. Van Blokland v. OHSU, supra. 87 Or App at 698. Treatment for a noncompensable condition is compensable under ORS 656.245(1) if the treatment would not have been undertaken but for the treatment required for a compensable condition. Williams v. Gates, McDonald & Co., 300 Or 278, 281 (1985); Van Blokland v. OHSU, supra, 87 Or App at 698.

The medical services rendered in connection with claimant's pneumonia and asthma were likely to be of curative benefit at the time when they were rendered. They, therefore, were reasonable and necessary.

Regarding the causal connection between claimant's compensable occupational disease and the need for the medical services, the compensable disease was asthma. The disease was permanent as evidenced by the award of unscheduled permanent partial disability. See Charles W. Roller, 39 Van Natta 504 (1987). This permanent condition flared-up and required medical treatment after claimant contracted pneumonia. The permanent condition -- claimant's compensable occupational disease -- was thus a significant cause of the need for the treatment of the April 1986 asthma flare-up and that treatment was compensable under ORS 656.245(1).

This leaves the question of whether the treatment for the pneumonia also was compensable. The pneumonia was in no way caused by claimant's compensable asthma condition. Pneumonia is a bacterial infection of the lungs and a person with asthma is at no greater risk of contracting pneumonia than a person without asthma. Also, by virtue of its infectious nature, the pneumonia would have required immediate treatment irrespective of the asthma flare-up. There was thus no material causal relation between the treatment of claimant's asthma and his pneumonia. Accordingly, we conclude that the medications prescribed for claimant's pneumonia and any other medical services rendered solely on account of that condition are not compensable under ORS 656.245(1). See Brooks v. D & R Timber, 55 Or App 688, 691-92 (1982); Vester v. Diamond Lumber Co., 21 Or App 587, 594-95 (1975).

ORDER

The Referee's order dated March 24, 1987 is reversed and modified. The insurer's denial dated April 21, 1986 is reinstated and upheld insofar as it denied claimant's aggravation claim for his asthma condition. The denial is set aside insofar as it denied all medical services related to claimant's April 1986

asthma flare-up. For establishing the causal relation between claimant's April 1986 asthma flare-up and his compensable occupational disease and obtaining the payment of medical services related to the flare-up, claimant's attorney is awarded $1,000 for services at the hearing and $400 on Board review, to be paid by the insurer. This attorney fee award is in lieu of, not in addition to, the Referee's award.

JOHN S. ROSENBERGER, Applicant
Ann Kelley, Assistant Attorney General

WCB CV-88002
May 24, 1988
Crime Victim Order

Applicant has requested review by the Workers' Compensation Board of Findings of Fact, Conclusions and an Order on Reconsideration issued by the Department of Justice Crime Victim Compensation Program ("Department") dated February 4, 1988. By its order, the Department denied applicant's claim for compensation as a victim of a crime under ORS 147.005 to 147.365. The Department based its denial on: (1) applicant's failure to file a claim for compensation within one year from the date of the criminal injury; and (2) a lack of evidence that applicant was mentally or physically incapable, as a direct result of the criminal injury, of timely filing the claim.

Following our receipt of the request for review, applicant was advised that he was entitled to a fact finding hearing before a Special Hearings Officer. To exercise his right to a hearing, he was instructed to notify the Board within 15 days from the date the Department mailed his copy of its record. The Department mailed a copy of its record to applicant on February 26, 1988. Having received no hearing request, we have conducted our review based solely on the written record. See OAR 438-82-030(2).

The standard for our review under the Act is de novo, based on the entire record. ORS 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.

FINDINGS

On October 30, 1987, applicant filed his claim for benefits under the Crime Victims Compensation Program. He requested benefits, stemming from an August 16, 1986 automobile accident that was caused by another driver. The driver was charged with Driving Under the Influence, Assault III (two counts), and Assault IV (two counts).

As a result of the accident, applicant suffered a severe broken leg, broken ribs, as well as numerous bruises and lacerations. He missed approximately two months of work. In October 1987, he returned to his employer and worked in a different capacity for two months, until his departure for reasons unrelated to his injuries.

Applicant was never advised of the existence of crime victim compensation or his potential eligibility under the program. He eventually learned of the program's existence through a newspaper article in the summer of 1987. Thereafter, he obtained an application and filed his claim.

Following its investigation, the Department found that the claim appeared to qualify for benefits in every aspect, except that it was filed more than one year after the date of injury. Since the record failed to establish that applicant was either physically or mentally incapacitated from timely filing the claim, the Department concluded that it must be denied.

Applicant requested reconsideration, asserting that his failure to timely file his claim was solely caused by the ineptitude of law enforcement officials, who had failed to inform him of the existence of the program. In addition, he asserted that, due to his injuries, he was entitled to a further extension of time within which to file his application.

Following a further investigation, the Department reconsidered its prior order. The Department acknowledged that applicant had sustained injuries as a result of the unprovoked crime. However, the Department was not persuaded that these injuries had prevented him from filing his claim in a timely manner. Accordingly, the Department found no basis for reversing its original order. Thereafter, applicant requested Board review.

CONCLUSIONS

Pursuant to ORS 147.015, applicant is entitled to an award under the Compensation of Crime Victims Act (Act), if, among other requirements:

> "(6) The application for an award of compensation under ORS 147.005 to 147.365 is filed with the Department:
>
> "(a) Within six months of the date of the injury to the victim; or
>
> "(b) Within such further extension of time of time as the department for good cause shown, allows."

Lack of knowledge of the Fund or failure of an investigating officer to provide information as provided in ORS 147.365 shall be deemed "good cause" for extending the time in which a claim must be filed. OAR 137-76-030(1). The extension consists of an additional six months beyond the six month period provided for in ORS 147.015(6)(a). Id. However, in the interest of orderly and consistent administration, no extension of time will be granted beyond one year from the date of injury, unless it is shown that failure to file was the result of mental or physical incapacity directly resulting from the criminal injury. OAR 137-76-030(2).

On de novo review of the record, we find that applicant's claim for benefits was filed more than one year after the date of injury. Therefore, the application was untimely. Furthermore, the record fails to establish that applicant's failure to timely file his claim was attributable to mental or physical incapacity directly resulting from his injury. Consequently, we conclude that the Department's Order on Reconsideration should be affirmed.

Since applicant was unaware of the Program or his

possible entitlement to benefits as the victim of a crime, he has established "good cause" for a sixth month extension of time within which to file his claim. See ORS 147.015(6)(b); OAR 137-76-030(1). Because the injury occurred on August 16, 1986, this extension would expire on August 16, 1987.

The application was not filed until October 30, 1987, more than one year after the injury. Consequently, applicant is entitled to a further extension of time to file his claim only if he was mentally or physically incapable of filing as a direct result of his injury. See OAR 137-76-030(2). The record indicates that applicant was physically incapacitated for a two month period following the accident. Thereafter, he was able to return to work in a more sedentary capacity for some two months, at which time he left his employment for reasons unrelated to his injuries. These circumstances suggest that, assuming he had been aware of the Program, applicant was neither physically nor mentally incapable of timely filing his claim. Accordingly, the claim must fail as untimely filed.

We take this action with regret. The record establishes that applicant was never informed of the potential availability of crime victim compensation. Rather, his application resulted from his own investigation, which had been prompted by a newspaper article. Unfortunately, the claim was submitted more than one year after the injury and the requirements for a further extension have not been satisfied. Thus, in a very real sense, applicant has been precluded from pursuing his claim for compensation by circumstances beyond his control. Although we sympathize with his dilemma, the statute specifically empowers the Department of Justice, but not the Board, to extend the time for good cause to six months. We are not empowered to question that judgement.

ORDER

The Findings of Fact, Conclusions and Order on Reconsideration of the Department of Justice Crime Victim Program dated February 4, 1988 is affirmed.

WILLIAM C. GORDON, Claimant
Malagon & Moore, Claimant's Attorneys
H. Thomas Andersen (SAIF), Defense Attorney

WCB 87-01952
June 17, 1988
Order on Review

Reviewed by Board Members Crider and Ferris.

Claimant requests review of those portions of Referee Daron's order which affirmed a Determination Order that awarded 20 percent (38.4 degrees) scheduled permanent disability for loss of use or function of the right arm, but declined to award scheduled permanent disability for the left arm or unscheduled permanent disability for the neck and shoulder. We affirm.

ISSUE

The extent of claimant's permanent disability, scheduled and unscheduled.

FINDINGS OF FACT

On or about November 9, 1981, claimant, a woodworker, compensably injured his right hand. Dr. Filarski, orthopedic surgeon, diagnosed stenosing tenovaginitis, right ring finger

tendon sheath. On July 16, 1982, he performed a trigger finger release on the third and fourth fingers of the right hand. Surgery relieved the triggering effect, but pain in the hand did not subside.

Dr. Cutler opined that claimant's right hand pain could be explained by the existence of a subluxing ulnar nerve at the right elbow. Therefore, On November 16, 1983, Dr. Matteri, orthopedic surgeon, performed an exploration and transposition of the right ulnar nerve at the medial epicondyle.

Claimant returned to light duty in January 1984. Within a few weeks, the hand numbness and elbow pain recurred. However, claimant exhibited normal shoulder, elbow, wrist, digital, and thumb joint motion as well as normal sensation, vascularity and muscle-tendon unit function in the right hand. There was no discernible evidence of weakness in the hand or any of the other muscles in the forearm or right upper extremity. The finger numbness which persisted was not an uncommon residual of an ulnar nerve transplant; such numbness is not, in itself, disabling.

The Orthopaedic Consultants described the loss of function of claimant's right arm as minimal and recommended that he continue with his same occupation.

A June 2, 1986 Determination Order awarded claimant 20 percent scheduled permanent disability for the right arm. That order, however, was rescinded. A second Determination Order issued on January 13, 1987, again granting claimant 20 percent scheduled permanent disability for loss of the right arm.

Claimant began having some neck, right shoulder and left arm pain. These subjective nondisabling pain complaints were not supported by objective medical evidence. There were no permanent restrictions of physical activity due to any left arm, neck, or shoulder problems. The medical evidence further indicated that the neck and shoulder complaints were probably not due to the compensable injury.

On October 8, 1986, the SAIF Corporation accepted claimant's left arm condition and agreed to process it to closure.

CONCLUSIONS OF LAW

The Referee made no specific credibility findings. On the merits, he declined to increase claimant's award of permanent disability, finding claimant had not shown a loss of use or function of the right arm greater than the 20 percent awarded pursuant to the Determination Order. No left arm disability was granted because of the lack of medical evidence indicating any impairment. No unscheduled shoulder or neck disability was granted because the medical evidence concerning causation was not persuasive. Also, no compensable loss of earning capacity was established. We agree.

When permanent partial disability results from an injury, the criteria for rating that disability shall be the permanent loss of use or function of the injured member due to the industrial injury. ORS 656.214(2). In all cases of injury resulting in permanent partial disability other than that described above, the criteria for rating of disability shall be the permanent loss of earning capacity due to the compensable injury. ORS 656.214(5).

At a hearing requested by a claimant on the issue of permanent disability, claimant has the burden of proving permanent disability "due to the compensable injury." ORS 656.214(5); Barrett v. D & H Drywall, 300 Or 325 (1985); David E. Sitton, 36 Van Natta 773 (1984). Therefore, claimant had the burden of proving a material causal connection between his shoulder or neck condition and his compensable injury. See Ernest E. Thompson, 39 Van Natta 455 (1987).

Claimant first reported neck and shoulder pain in May 1984. At that time, he exhibited full neck range of motion. Dr. Ellison reported that claimant's shoulders were normal. No musculoskeletal injury at the shoulder was producing claimant's subjective complaints. A cervical myelogram ruled out any right cervical disc problems.

Dr. Filarski opined that claimant's neck and shoulder complaints were not causally related to the original on-the-job accident.

On the other hand, Dr. Glubka, chiropractor, felt that it was more likely than not that claimant's neck and shoulder problems were related to his original injury. He further characterized the degree of impairment that claimant suffered as a result of these conditions as moderate.

Claimant offered medical evidence attempting to establish that the shoulder and neck conditions were related to the compensable injury. SAIF offered evidence to the contrary. Dr. Glubka's opinion consisted of a conclusory statement without supporting explanation. We do not find it persuasive. Moe v. Ceiling Systems, 44 Or App 429 (1980). Accordingly, we conclude that claimant did not prove by a preponderance of the evidence that his shoulder and neck symptoms were materially related to the original compensable condition.

We further conclude that it was appropriate for the Referee to make an independent determination of whether claimant's shoulder and neck conditions were related to his compensable injury. We agree that claimant failed to carry his burden. Therefore, no unscheduled disability is awarded. David E. Sitton, supra.

Assuming arguendo that claimant had established a material relationship between his compensable injury and the shoulder and neck complaints, we still would not grant claimant any unscheduled permanent disability. We base this conclusion on the lack of persuasive medical evidence to establish any permanent limitations or restrictions of physical activity from the neck or shoulder problems. Although probative, claimant's testimony, by itself, did not establish a loss of earning capacity. Garbutt v. SAIF, 297 Or 148 (1984).

Likewise, there was no medical evidence of any loss of use or function of the left arm. Claimant merely testified to pain centered around the elbow. By his own admission, this pain was minimal and did not bother him. Therefore, claimant is not entitled to an award of scheduled permanent disability for the loss of use or function of his left arm.

The medical evidence is unanimous that claimant's right arm was physically impaired. Two surgeries failed to alleviate the hand numbness. The ulnar nerve transposition contributed chronic elbow pain. However, the medical evidence also established that, objectively, claimant retained nearly all of his right arm functions. Following elbow surgery, he exhibited full range of motion in his right elbow. He had normal strength and sensation in his right hand, and showed good abduction and adduction of the fingers.

Following our review of the medical and lay evidence we agree with the Referee that 20 percent scheduled permanent disability adequately compensates claimant for the loss of use or function of his right arm.

ORDER

The Referee's order dated July 30, 1987, is affirmed.

TORIA S. BENSON, Claimant
Roberts, et al., Defense Attorneys

WCB 85-14056 & 84-01712
June 21, 1988
Order on Review

Reviewed by Board Members Johnson and Crider.

Claimant, pro se, requests review of those portions of Referee Knapp's order that: (1) upheld the self-insured employer's denial of her claim for neck, back, and psychological stress conditions; and (2) upheld the employer's "de facto" denial of her claim for an alleged chemical sensitivity condition.

We reverse in part and affirm in part.

ISSUES

1. Whether claimant's case should be remanded to the Referee.

2. Whether claimant's industrial traumas of October 1983 materially contributed to her neck, back, or psychological stress conditions.

3. Whether claimant's industrial exposure to tar fumes in October 1983 caused or worsened her alleged chemical sensitivity condition.

4. Whether claimant timely filed an occupational disease claim for her psychological stress condition.

5. Whether claimant's work activities caused or worsened her psychological stress condition.

FINDINGS OF FACT

The Board adopts the Referee's findings and make the following additional findings.

Claimant had sought medical attention for complaints of pain in her neck, shoulders, and back prior to October 1983. On October 4, 1983, she injured her neck, shoulders, and back following a physical confrontation with one of her students. Her pain increased following two similar confrontations on October 6 and 7, 1983. As a result of the October 1983 traumas, she sustained increased symptoms in her neck, shoulders, and back.

Claimant had sought medical attention for anxiety and psychological stress prior to October 1983. The injury of October 4, 1983, frightened claimant and caused her to recall a painful event in her childhood. As a result of the October 1983 traumas, she sustained increased symptoms of psychological stress.

On Board review, claimant has attached several documents to her written argument that are not contained in the record. These documents include copies of medical reports, medical articles, and newspaper articles.

CONCLUSIONS OF LAW

1. Remand

The Board's review shall be based upon the record and such oral or written argument as it may receive. ORS 656.295(3) & (5). Remand to the Referee is appropriate if the Board finds that the record has been "improperly, incompletely or otherwise insufficiently developed." ORS 656.295(5).

Here, claimant has attached several documents to her written argument that are not contained in the record. We construe the submission of such documents as a request for remand. After our de novo review, we find that the record was properly, completely, and sufficiently developed. See ORS 656.295(5). We, therefore, decline to remand.

2. Compensability of Neck, Back, and Psychological Stress Conditions

The Referee concluded that claimant's injury claim was not compensable, inasmuch as she had not proven "an aggravation of her underlying [neck, back, or psychological stress] conditions." We disagree.

At the outset, we must determine whether claimant's October 1983 traumas can properly be characterized as an industrial injury rather than an occupational disease. In Valtinson v. SAIF, 56 Or App 184, 187 (1982), the court provided:

> "'What set[s] occupational diseases apart from accidental injuries [is] both the fact that they can [not] honestly be said to be unexpected, since they [are] recognized as an inherent hazard of continued exposure to conditions of the particular employment, and the fact that they [are] gradual rather than sudden on onset.'" [quoting O'Neal v. Sisters of Providence, 22 Or App 9, 16 (1975)].

The first prong of this two-part test requires a determination of whether the medical condition claimed would likely result from the work activity alleged to be the cause of the condition. The second prong requires a finding of whether the alleged medical condition was "sudden in onset."

Here, claimant was employed as a public school teacher. Her classroom consisted of approximately 30 fourth and fifth grade students. In the course of her teaching duties, she sustained three discrete physical traumas on October 4, 6, and 7, 1983.

Each trauma involved a physical confrontation with one of her students.

We conclude that teaching fourth and fifth grade students in a public school system was unlikely to result in the conditions claimed by claimant. We also conclude that a period of four days, involving three discrete physical traumas, satisfies the "sudden in onset test" requirement. Accordingly, claimant's October 1983 traumas are properly characterized as an industrial injury.

In injury cases, a worker must prove by a preponderance of the evidence that the industrial injury was a material contributing cause of her existing disability or need for medical services. Harris v. Albertson's Inc., 65 Or 254, 257 (1983); ORS 656.005(8)(a). A worker need not, however, prove an aggravation or worsening of her underlying condition. Jameson v. SAIF, 63 Or App 553, 555 (1983); Boise Cascade v. Wattenbarger, 63 Or App 447 (1983). Accordingly, in Harris the court announced, inter alia:

> "The referee incorrectly applied the standard of proof set out in Weller v. Union Carbide, . . . [288 Or 27 (1979)], in finding this claim noncompensable. When a disability is the result of an accidental injury, rather than an occupational disease, Weller does not apply. [Citation omitted]. In injury cases, the correct standard of proof is that a claimant must establish by a preponderance of the evidence that the industrial injury was a material contributing cause of the existing disability."

a. Neck and Back

Here, claimant experienced pain in her neck and back shortly after the trauma of October 4, 1983. Her pain increased following the ensuing traumas of October 6 and 7, 1983. Moreover, nearly all of the medical experts causally related claimant's neck and back disability to the October 1983 traumas.

Dr. Schoepflin testified, inter alia:

> "They [the October 1983 traumas] certainly were the cause of increased symptoms for a period of time . . . ."
>
> "* * * * *
>
> "It [the October 1983 traumas] likely worsened symptoms, and whether it was sufficient to aggravate the condition itself on the long term is impossible for me to say." (Emphasis added).

Dr. Nelson reported that claimant's degenerative arthritis of the acromioclavicular joints was "aggravated by the on-the-job injury of October 4, 1983."

Dr. Bennett diagnosed claimant's neck and back disability as myofascial pain syndrome. According to Bennett, the

syndrome was "post-traumatic in origin following [the October 1983] trauma to her neck and shoulders . . . ."

Dr. Rohlfing diagnosed claimant's neck and back disability as preexisting fibrositis and opined that it remained unchanged after October 1983. However, Rohlfing conceded that before October 1983 claimant's condition was "kind of unknown to me."

Dr. Franks reported that claimant might have fibromyositis, but did not feel it was "directly related to the trauma of October 4, 1983."

Dr. Reimer was the only physician to unequivocally state that there was no relationship between claimant's complaints and the October 1983 traumas.

We are persuaded by Schoepflin's opinion. Schoepflin began treating claimant in 1981 and has observed her on several occasions. See Weiland v. SAIF, 64 Or App 810, 814 (1983). Moreover, inasmuch as Schoepflin observed claimant both before and after the October 1983 traumas, he was in the best position to render an opinion concerning the causal relationship of those traumas to claimant's neck and back disability. See Kienow Food Stores v. Lyster, 79 Or App 416, 421 (1986). Schoepflin's opinion is further buttressed by the opinions of Nelson and Bennett.

We are not persuaded by the opinions of Rohlfing, Franks, and Reimer. First, Rohlfing testified that claimant's fibrositis condition did not change after October 1983. However, Rohlfing admitted that he had little firsthand knowledge in which to render an opinion concerning a comparison of claimant's condition before and after October 1983. See Kienow Food Stores v. Lyster, supra. Second, Franks merely opined that claimant's condition was not "directly" related to the October 1983 traumas. The implication from Frank's opinion, however, is that claimant's condition was indirectly related to the October 1983 traumas. See Bloomfield v. National Union Insurance Co, 72 Or App 126, 128-29 (1985) (Industrial injury need not be the sole or principal cause of a worker's disability). Last, Reimer did not examine claimant for complaints related to her neck and back. Accordingly, Reimer reported, inter alia:

> "She [claimant] is here primarily . . . to have a neurological evaluation because she is wondering if she has had neurological damage as a result of her 10/4/83 injury." (Emphasis added).

Reimer concluded his report by describing the various neurological examinations which he had performed. There is no mention, however, of any neck or back examinations. Therefore, while we do not discount Reimer's opinion, we accord it little probative weight.

Accordingly, claimant has proven that the October 1983 traumas materially contributed to her existing neck and back disability.

b. Psychological Stress

The issue of whether claimant's October 1983 traumas materially contributed to her existing psychological disability or

need for medical services is a complex medical question. Thus, although claimant's testimony is probative, resolution of this issue largely turns on an analysis of the medical evidence. Uris v. Compensation Department, 247 Or 420, 426 (1967); Kassahn v. Publishers Paper Co., 76 Or App 105, 109 (1985).

Claimant was examined by Dr. Sissler on four occasions in 1985. According to Sissler, the October 1983 traumas "caused [claimant] to have a mental disorder." Similarly, Dr. Colistro opined that claimant was suffering from an acute adjustment disorder and an aggravation of a preexisting personality disorder, which both became problematic after her October 1983 traumas. On the other hand, Dr. Parvaresh testified the claimant did not suffer any psychological disability as a result of the October 1983 traumas.

We are more persuaded by the opinions of Sissler and Colistro. See Somers v. SAIF, 77 Or App 259, 263 (1986). Unlike Sissler, Parvaresh examined claimant on only one occasion. See Weiland v. SAIF, 64 Or App at 814. Moreover, Parvaresh conceded that it was possible for a minor physical event to have serious effects on an individual's psychological functioning. He further conceded that individuals do not usually divulge important childhood events after only one or two psychiatric evaluations. Here, in the course of Sissler's treatment, claimant connected the October 1983 traumas to certain traumatic childhood events. We conclude, therefore, that Parvaresh's opinion was not based on a complete and accurate history. See Miller v. Granite Construction Co., 28 Or App 473, 476 (1977).

Accordingly, we conclude that claimant has proven that the October 1983 traumas materially contributed to her existing psychological disability.

3. Chemical Sensitivity

To establish a compensable occupational disease, a worker must prove that her work exposure was the major contributing cause of either the onset or worsening of her condition. Dethlefs v. Hyster Co., 295 Or 298, 310 (1983); Weller v. Union Carbide Corp., 288 Or 27, 31-5 (1979); see former ORS 656.802(1)(a).

The issue of whether claimant suffered a compensable chemical sensitization condition as a result of tar fume exposure, is, again, a complex medical question. Uris v. Compensation Dept., supra; Kassahn v. Paper Publisher's Co., supra.

The medical evidence is divided. Drs. Parvaresh, Colistro, Bardana, Morton, and O'Hallaren found no evidence of toxic poisoning or organic brain damage. On the other hand, Drs. Keppel, Leveque, and Pletsch diagnosed a chemical sensitivity condition. Keppel and Leveque, however, did not causally relate claimant's alleged chemical sensitivity to her tar fume exposure in October 1983. Likewise, Pletsch only stated that chemical sensitivity "usually begins after some exposure to a chemical substance (in this case tar fumes)." Although we are aware that a physician need not use precise legal terminology, McClendon v. Nabisco Brands, Inc., 77 Or App 412, 417 (1986), we are not persuaded by Pletsch's opinion concerning the "usual" causal relationship between chemical sensitivity and tar fumes.

Accordingly, we conclude that claimant has not proven that her work exposure in October 1983 was the major contributing cause of either the onset or worsening of an alleged chemical sensitivity condition.

4. Timeliness of Occupational Stress Claim

The Referee found that claimant had not filed an occupational disease claim for her psychological stress condition until the date of the hearing. He, therefore, concluded that the claim was untimely. We disagree.

Occupational disease claims must be filed within 180 days from the date a worker becomes disabled or is informed by a physician that she is suffering from an occupational disease, whichever is later. Former ORS 656.807(1). However, an untimely filing under former ORS 656.807(1) does not bar a worker's claim if: (1) the employer had knowledge of the injury; or (2) the insurer or self-insured employer was not prejudiced by failure to receive timely notice. ORS 656.265(4)(a); Robinson v. SAIF, 69 Or App 534, 538 (1984); see Inkley v. Forest Fiber Products Co., 288 Or 337, 347 (1980).

Here, claimant filed an industrial claim for neck, back, and psychological stress conditions on November 21, 1983. On the claim form, she expressly indicated that her conditions arose out of traumas sustained on October 4, 6, and 7, 1983. The following day, the employer checked the box for an "occupational disease" and placed the claim in "deferred" status. On January 23, 1984, the employer issued a letter of denial stating, inter alia:

> "You [claimant] claimed back, neck and stress problems and alleged that these problems arose out of your teaching activities at Bridger School."
>
> "* * * * *
>
> "In 1977[,] Dr. Larson mentioned that you were troubled greatly by your problems of on going anxiety and that you had spent some time with a psychologist." (Emphasis added).

First, we are not persuaded that claimant filed an untimely occupational disease claim. In fact, the record indicates that the employer initially viewed the November 1983 claim as one for occupational disease.

Second, even assuming that claimant filed an untimely occupational disease claim, we find that her claim was not time-barred. The employer clearly had knowledge of claimant's "injury." ORS 656.265(4)(a); see Hayes-Godt v. Scott Wetzel Services, 71 Or App 175, 179 (1984). Moreover, based on the employer's own "check the box" responses in claimant's initial claim form and its letter of denial, the employer had knowledge of a claim for occupational disease.

Last, as early as November 22, 1983, the employer was aware of an occupational disease claim for psychological stress.

Upon investigating the claim, it learned of claimant's long-standing anxiety condition. A few months after denying claimant's stress condition, the employer sent claimant to Parvaresh for a psychiatric evaluation. Under such circumstances, we conclude that the employer failed to prove that it was prejudiced by claimant's alleged failure to timely file an occupational disease claim. See Robinson v. SAIF, 69 Or App at 538; Hayes-Godt v. Scott Wetzel Services, 71 Or App at 180.

5. Psychological Stress Condition--Related to Work Activities

To establish a compensable occupational disease for a psychological condition, the worker must prove that her work activities were the major contributing cause of the condition. Dethlefs v. Hyster Co., 295 Or at 310. If the psychological condition preexisted her employment, the worker must prove that her symptoms increased. Varner v. SAIF, 89 Or App 421, 424 (1988); Adsitt v. Clairmont Water District, 79 Or App 1, 7 (1986).

Here, although the record supports a finding that claimant's psychological condition preexisted her October 1983 traumas, there is no evidence that it preexisted her employment. We, therefore, need not apply the rule announced in Adsitt to our occupational disease analysis of claimant's psychological condition.

As we stated above, Sissler, Colistro, and Parvaresh have rendered opinions concerning the etiology of claimant's psychological condition. While Sissler and Colistro causally related claimant's psychological condition to the October 1983 traumas, they did not relate claimant's condition to her work activities.

Accordingly, we conclude that claimant has not proven that her work activities were the major contributing cause of her psychological condition.

ORDER

The Referee's order dated August 18, 1987 is reversed in part and affirmed in part. Those portions of the Referee's order that upheld the self-insured employer's denial of claimant's November 1983 claim for neck, back, and psychological stress conditions, and found that claimant's occupational disease claim for her psychological stress condition was untimely, are reversed. The employer is directed to process claimant's November 1983 claim according to law. All remaining portions of the Referee's order are affirmed. The Board approves a client-paid fee not to exceed $736.50.

ANDY WEBB, Claimant
Hayner, et al., Claimant's Attorneys
SAIF Corp, Insurance Carrier

Own Motion 88-0144M
June 22, 1988
Own Motion Order on Reconsideration

Claimant has requested reconsideration of our April 25, 1988 Own Motion Order which concluded that we lacked authority to reopen his September 12, 1979 injury claim with the SAIF Corporation for the payment of temporary total disability benefits. Relying on ORS 656.278(1)(a), which became effective January 1, 1988, we reasoned that we may exercise our own motion authority when we find that there is a worsening of a compensable injury that requires either inpatient or outpatient surgery or

other treatment requiring hospitalization. Inasmuch as claimant had neither undergone surgery nor been hospitalized for treatment concerning his back condition, we concluded that we were without authority to reopen the claim for the payment of temporary total disability benefits. Consequently, we denied claimant's request for Own Motion relief.

On May 25, 1988, we abated our Own Motion Order and granted SAIF an opportunity to respond to claimant's request for reconsideration. Having received SAIF's response, we proceed with our reconsideration.

Claimant contends that the Board failed to consider the law in effect at the time of claimant's 1979 injury. In support of his contention, claimant cites ORS 656.202(2), which provides that:

> "Except as otherwise provided by law, payment of benefits for injuries or deaths under ORS 656.001 to 656.794 shall be continued as authorized, and in the amounts provided for, by the law in force at the time the injury giving rise to the right to compensation occurred."

Furthermore, claimant submits that House Bill 2900 (which became Oregon Laws 1987, Chapter 884) did not amend, modify or otherwise alter the aforementioned statute. Consequently, claimant asserts that the Board's Own Motion authority in this claim is not limited by Section 37 of Chapter 884. (Which amended ORS 656.278(1) by limiting awards to temporary disability compensation from the time the worker is actually hospitalized or undergoes outpatient surgery until the worker's condition becomes medically stationary as determined by the Board).

Contending that the Board had authority to award temporary total disability at the time of his 1979 injury and at the time of his 1987 request for Own Motion relief, claimant argues that the Board is empowered to grant his request. We disagree.

Section 37 of Chapter 884, which amended ORS 656.278(1) as previously described, became operative January 1, 1988. See Section 63. Moreover, these amendments became operative on January 1, 1988, "[n]otwithstanding ORS 656.202." See Oregon Laws 1987, Chapter 884, Section 62. (Emphasis added).

In addition to the amendments to ORS 656.278(1), Chapter 884 also created ORS 656.625, the "Reopened Claims Reserve." See Oregon Laws 1987, Chapter 884, Section 39. ORS 656.625(1) provides that the Director "shall establish a Reopened Claims Reserve within the Insurance and Finance Fund for the purpose of reimbursing the additional amounts of compensation payable to injured workers that results from any award made by the board pursuant to ORS 656.278 after January 1, 1988." ORS 656.625(2) further states that "[n]otwithstanding any other provision of law, any reimbursement from the Reopened Claims Reserve shall be in such amounts as the board prescribes and only to the extent that funds are available in the reserve." As with the other sections of Chapter 884, Section 39 became operative January 1, 1988. See Chapter 884, Section 63.

The language of the aforementioned statutes unambiguously

expresses the intent of the legislature that the Board's authority to award compensation after January 1, 1988 is limited to temporary disability benefits and only when there is a worsening of a compensable injury that requires either inpatient or outpatient surgery or other treatment requiring hospitalization. Thus, it is not necessary to resort to statutory construction principles or to legislative history to determine the intent of the legislature. Whipple v. Howser, 291 Or 475 (1981). Even assuming that ambiguities exist, the legislative history supports the conclusion that the legislature intended to limit all awards for claims in which the worker's aggravation rights had expired to temporary disability, payable only where there has been a worsening of a compensable injury requiring either surgery or other treatment requiring hospitalization. See Minutes, Senate Committee on Labor, Pages 29 - 35, (June 10, 1987).

Finally, claimant objects to the issuance of our order with notice of appeal rights pursuant to ORS 656.278(3). At a minimum, claimant suggests that our order be modified to allow him the right to petition for judicial review. We are without authority to alter our notice of appeal rights.

Inasmuch as claimant has requested relief under our Own Motion authority, we are obliged to issue an order pursuant to that authority. Therefore, in accordance with ORS 656.278(3), we are required to advise the parties of their respective rights of appeal from our Own Motion order.

Accordingly, the request for reconsideration is granted. On reconsideration, as supplemented herein, we adhere to and republish our April 25, 1988 order, effective this date.

IT IS SO ORDERED.

WALLACE J. DAVIS, Claimant
David J. Hollander & Assoc., Claimant's Attorneys
The Travelers, Insurance Carrier

Own Motion 87-0744M
June 23, 1988
Own Motion Order

The Board issued an Own Motion Determination on April 15, 1988 whereby claimant's claim was closed with temporary total disability compensation terminated as of March 4, 1988. Claimant subsequently requested that the Board reconsider its order and presumably increase the permanent disability award beyond the 65 percent claimant had already been granted. Before claimant was able to present the additional medical evidence to support his request, the insurer advised us that claimant was again seeking temporary total disability compensation for an alleged worsening of his compensable claim. The insurer opposes this relief as there was no surgery recommended and claimant had not been working. Claimant contends his hospitalization qualifies him for further temporary disability benefits.

Pursuant to ORS 656.278(1)(a), we may exercise our "Own Motion" authority when we find that there is a worsening of a compensable injury that requires either inpatient or outpatient surgery or other treatment requiring hospitalization. In such cases, we are authorized to award temporary disability compensation commencing from the time the worker is actually hospitalized or undergoes outpatient surgery. Claimant's hospitalization in May 1988 did result in treatment for his compensable condition. On that basis, we find he could be entitled to claim reopening. We note that claimant received

temporary total disability compensation until March 1988. Shortly thereafter, he began working with a vocational consultant in an attempt to identify an appropriate work goal for himself. We conclude claimant has not removed himself from the work force and would be entitled to compensation under Cutright v. Weyerhaeuser Company, 299 Or 290 (1985).

Accordingly, claimant's claim is reopened with temporary total disability compensation to commence May 26, 1988 and to continue until claimant returns to his regular work at his regular wage or is medically stationary, whichever is earlier. Claimant's attorney is awarded 25% of the additional compensation granted by this order, not to exceed $450 as a reasonable attorney's fee. Reimbursement from the Reopened Claims Reserve is authorized to the extent allowed under ORS 656.625 and OAR 436, Division 45. When appropriate, the claim shall be closed by the insurer pursuant to OAR 438-12-055.

IT IS SO ORDERED.

ANNETTE PRESTON, Claimant
Pozzi, et al., Claimant's Attorneys
Lyons & Scheminske, Defense Attorneys

WCB 87-13133
June 23, 1988
Order on Review

Reviewed by the Board en banc.

The insurer requests review of that portion of Referee Podnar's order that set aside its denial of claimant's occupational disease claim for an allergy condition.

ISSUE

Whether claimant's exposure to flour dust in the course of her employment was the major contributing cause of the onset or worsening of her allergy condition.

FINDINGS OF FACT

Claimant began working in the employer's baked goods factory in April 1979 and was still working there at the time of the hearing in December 1987. Between April 1979 and approximately February 1984 claimant worked first as a muffin packer and then as a pan setter. As a pan setter, claimant placed pans under the outlet of a machine which filled them with dough. The function of a muffin packer was not described in the record. Both of these positions exposed claimant to significant amounts of airborne flour dust. In about February 1984, claimant changed positions from pan setter to wrapper. As a wrapper, her main function was to remove wrapped packages of baked goods from a conveyor belt and place them on racks. She also performed other chores on a daily basis such as loading ovens and cleaning the wrapping machine with an air hose. This position exposed her to less flour dust than her previous positions had. She wore no protective mask until approximately May 1987. She has never been exposed to significant concentrations of flour dust off the job.

In mid 1983, claimant began experiencing symptoms which included hoarseness, frequent throat clearing, coughing, occasional loss of voice, excessive tearing of the right eye and nasal congestion and discharge. These symptoms improved whenever claimant was off work for several days. Claimant filed a claim in connection with her symptoms in March 1987.

Claimant began treating with Dr. O'Hallaren, an allergy specialist, in May 1987. Dr. O'Hallaren performed intradermal tests which revealed that claimant was highly allergic to many common inhalant allergens including environmental pollens, house dust and animal dander. The tests also revealed allergic reactions to barley, corn, rice, rye, wheat, string beans, lettuce and coffee. Claimant's medical history also includes an allergic reaction to citrus fruit in September 1972.

Claimant's eye, nose and throat symptoms are due to an atopic diathesis, a hereditary predisposition to react to certain allergens, including the substances to which she was exposed at work. Her exposure to flour dust in the course of her employment contributed more to the production of her eye, nose and throat symptoms than all other potentially contributing exposures combined.

OPINION AND CONCLUSIONS

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

Claimant's exposure to flour dust in the course of her employment contributed more to the production of her eye, nose and throat symptoms than all other potentially contributing exposures and thus was the major contributing cause of those symptoms. Claimant's disease, however, is her sensitivity to substances found in flour dust. This sensitivity is hereditary and thus preceded her employment in the employer's factory. Claimant, therefore, must show a worsening of her underlying condition in order to prevail. Weller v. Union Carbide Corp., supra, 288 Or at 35.

The record is devoid of any medical evidence that claimant's exposure to flour dust at work in any way worsened her underlying sensitivity to the substances found in flour dust. A worsening is perhaps suggested by the fact that claimant worked in the employer's factory for about four years without reported symptoms and then reacted to the flour dust in mid 1983. Without expert medical guidance, however, we are unable to decide this complex medical question. See Uris v. Compensation Department, 247 Or 420, 424-26 (1967). We conclude, therefore, that claimant has failed to prove a worsening of her underlying condition and that her claim is not compensable. See Wheeler v. Boise Cascade, supra, 298 Or at 454-55, 457.

ORDER

The Referee's order dated January 5, 1988 is reversed. The

insurer's denial dated August 3, 1987 is reinstated and upheld. Counsel for the insurer is authorized to charge a client-paid fee of up to $1,585 for services on Board review.

Board Member Crider, dissenting:

I dissent. The Referee correctly concluded that the claim is compensable.

The majority characterizes claimant's condition or disease as "atopic diathesis" (a condition described by the Attorney's Dictionary of Medicine as "an allergic predisposition to disease"). Although that predisposition has never been disabling and has never required medical services, the majority characterizes as mere symptoms the rhinitis for which she filed a claim, even though the rhinitis is the only problem which has required treatment. Then, finding that claimant's allergic predisposition was not worsened by her occupational exposure, the majority finds the claim not compensable. The result is incorrect, given the record, whether the condition is described as the allergy or the rhinitis.

Claimant never suffered from rhinitis until she began work in the insured's bakery. There she was regularly exposed to flour dust and developed rhinitis--persistent scratchiness of the throat, watery eyes, chronic postnasal drip, cough and the like. Her condition improved whenever she was removed from the work environment. Although an allergist to whom she was referred by her family doctor discovered, upon testing, that claimant was allergic tc many substances, there is no evidence that claimant actually sufferec in any way when exposed in ordinary life to any of these allergens. There is further no evidence that exposure to other allergens would cause rhinitis. In fact, the allergist's uncontradicted opinion, apparently accepted by the majority, was that claimant's "atopic diathesis with allergic rhinitis" was "undoubtedly aggravated by exposure to wheat dust and perhaps other cereal dusts at the work environment." He further stated that "she probably has a rhinitis aggravated by the work environment" and that the work exposure was "the precipitating factor to her nasal and throat problems."

This is a classic occupational disease. The evidence establishes that the workplace exposure caused either the onset or the exacerbation of claimant's clinical condition--rhinitis. It is, therefore, compensable. Although the treating allergist did not use the term "major contributing cause", the Referee and the Board majority correctly conclude that the workplace exposure was the majo cause, when compared with all other exposures, of the rhinitis. This is sufficient. See Hutcheson v. Weyerhaeuser, 288 Or 51 (1979); McClendon v. Nabisco Brands, Inc., 77 Or App 412 (1986).

Implicit in the majority's contrary holding is a doctrine which would render noncompensable any condition suffered as a result of occupational exposure by a person with an allergic sensitivity to the substance whether or not that person is exposed to the substance off the job. Put another way, it renders noncompensable any condition suffered by a worker as a result of exposure to a substanc present in the workplace unless either a similar exposure would be toxic as to workers in general or the exposure caused a heightening of the worker's unusual sensitivity to the substance. Such a doctrine is contrary to the case law and has no place in a worker's compensation system that purports to take the worker as it finds her

First, the case law. The courts of this state have held that respiratory difficulties brought on or exacerbated by work exposures are compensable even though a worker has an allergic sensitivity to the substance in question. Thus, in Collins v. Hygenic Corporation of Oregon, 86 Or App 484 (1987), the court reversed a Board order upholding denial of a condition characterized by "transitory airways symptoms" brought on when the worker was exposed to a chemical spray used at work. Although claimant's medical experts were unable to give the condition a diagnosis and although it was acknowledged that the spray would be irritating only to "hypersensitive individuals", the court found that because the exposure was the major contributing cause of the symptoms which required medical services, the claim was compensable. In other words, where a worker does not ordinarily suffer from the type of respiratory ailments brought on by a job exposure, those ailments are compensable even though they were brought on by the exposure superimposed on claimant's personal sensitivity.

The Court of Appeals holding in Collins was consistent with the Supreme Court's discussion of occupational disease in Dethlefs v. Hyster Co., 295 Or 298 (1983). That case involved claims for vasomotor rhinitis and allergic rhinitis. The Court, while affirming the Court of Appeals' conclusion that the vasomotor rhinitis was compensable, observed that the Court of Appeals had found that claimant's allergic rhinitis was not caused by occupational exposure. The Court went on to say that:

> "[I]nherent in its decision that the allergic rhinitis is not compensable is a finding that the claimant was ordinarily exposed away from work to house dust, house dust mites, new mown grass and other stimuli which produced his allergic response and the symptoms thereof encompassed in the diagnosis of allergic rhinitis."

Dethlefs v. Hyster Co., supra, 295 Or at 310, n. 11. Necessarily then, an allergic rhinitis will be compensable where work exposure is the major contributing cause of the rhinitis. There need be no proof that what the Board now calls the "underlying allergy condition" was worsened by the occupational exposure to establish compensability.

Despite this line of cases, the majority describes claimant's disease not as the "atopic diathesis with allergic rhinitis" diagnosed by the treating physician but as "atopic diathesis" and, seizing on that label, denies compensation to an individual who suffered a malady that clearly arose on the job. The Board builds its edifice on a distinction between the "disease" and its symptoms" that the medical experts in this case never made. This is, at best, unfortunate. Many conditions to which medical professionals attach "disease" labels are in fact no more than descriptions of symptoms. Thus, they refer to "bronchitis" meaning inflammation of the bronchi; "sinusitis" meaning inflammation of a sinus; or "anxiety reaction" meaning, I take it, anxiety reaction. And, quite reasonably, although these are but descriptions of symptoms, we do not suggest that they are not compensable when induced by on-the-job activity or exposure. Indeed, we do not require that a label be affixed to the symptoms at all as a prerequisite to compensability. Collins v. Hygenic Corporation of Oregon, supra; Robinson v. SAIF, 78 Or App 581 (1986). That being the case, there is no reason why rhinitis,

though but a description of an inflamed condition that carries with it a constellation of troubles, should be treated differently simply because the clinical condition would not have arisen but for the unusual sensitivity of the claimant.

It is a fundamental tenent of our workers' compensation system that we take the worker as we find him. Hutcheson v. Weyerhaeuser, supra. We do not say that because a claimant would not have suffered an injury due to an on-the-job occurrence but for a preexisting weakness, his injury is not compensable. On the contrary, if the occurrence is a material cause of the injury, it is compensable. The same principle applies to occupational diseases. The major contributing cause test requires us to find on-the-job exposures; but it does not mean that we treat the worker's personal weaknesses as the disease and the clinical condition brought about by the exposure as mere symptoms. An allergy is no more a disease than an eggshell skull is an injury. Neither itself causes disability or need for treatment; but each makes the individual far more likely than the average person to suffer disability or to require treatment after a minor occupational incident or exposure. Neither is itself compensable; but neither, when its combination with occupational exposure results in a condition creating disability or requiring medical services, disqualifies the worker from receipt of workers' compensation benefits.

The order of the Referee should be affirmed.

The Beneficiaries of
THOMAS McBROOM (Deceased), Claimant
Pozzi, Wilson, et al., Claimant's Attorneys
Roberts, et al., Defense Attorneys
Joseph D. Davis, Attorney

WCB TP-87029
June 24, 1988
Third Party Order Denying Reconsideration

The paying agency has requested abatement and reconsideration of the Board's May 25, 1988 Third Party Distribution Order that: (1) found that claimant, as beneficiary of the estate of the deceased worker, did not assign her third party action to the paying agency; and (2) concluded that claimant was entitled to her statutory 1/3 share of the proceeds of the third party judgment pursuant to ORS 656.593(1)(b).

Enclosing a document which has previously not been submitted into the record for our review, the paying agency asks that our order be reconsidered and reversed. We decline to grant the request.

The document in question is a copy of a September 25, 1981 written demand from the paying agency to claimant requesting that it be advised as to whether she had elected to proceed against the third party. The existence of this document does indicate that the paying agency complied with the provisions of ORS 656.583, which is contrary to findings rendered in our prior order. However, its existence does not alter our ultimate conclusions that claimant elected to proceed against the third party on her own behalf and, subsequently, did not assign her cause of action to the third party.

The agency's remaining contentions have either been previously considered or are not germane to the issue at hand.

i.e., whether claimant assigned her cause of action to the paying agency and her entitlement to a 1/3 share of the remaining balance of proceeds from a third party judgment.

Accordingly, the request for abatement and reconsideration is denied.

IT IS SO ORDERED.

ROYD C. BROTHERSON, Claimant
Walter D. Alley, Claimant's Attorney
Nelson, et al., Defense Attorneys

WCB 87-16806
June 28, 1988
Order of Dismissal

The insurer has moved the Board for an order dismissing claimant's request for review on the ground that it did not receive timely notice of the request. The motion is granted.

FINDINGS

Claimant's request for review of the Referee's February 24, 1988 order was hand-delivered to the Board on March 23, 1988. The request did not include an acknowledgment of service or a certificate of personal service by mail upon the other parties at the hearing. Neither the insurer nor its attorney received a copy of claimant's request for review.

On March 31, 1988, the Board mailed a computer-generated letter to all parties acknowledging the request. The insurer received the acknowledgment on April 1, 1988. This was its first notice of claimant's request for review.

The request for Board review was filed within 30 days of the Referee's order. However, neither the insurer nor its attorney received notice of claimant's request for review within 30 days after the date of the Referee's order.

CONCLUSIONS

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

Here, the 30th day after the Referee's February 24, 1988 order was March 25, 1988. Thus, claimant's request for Board review was timely filed. See ORS 656.289(3). However, neither the insurer nor its representatives were timely provided with, 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 v. King, supra.

We are mindful that claimant has requested review without benefit of legal representation. We further realize that an unrepresented party is not expected to be familiar with administrative and procedural requirements of the Workers'

Compensation Law. Yet, we are not free to relax a jurisdictional requirement, particularly in view of Argonaut Insurance Co. v. King, supra. See Alfred F. Puglisi, 39 Van Natta 310 (1987); Julio P. Lopez, 38 Van Natta 862 (1986).

Accordingly, the request for Board review is dismissed.

IT IS SO ORDERED.

LEON C. BUZARD, Claimant
VanVactor & Ellingson, Claimant's Attorneys
Kate Waldo (SAIF), Defense Attorney
Marcus K. Ward, Defense Attorney

WCB 84-09887 & 85-05168
June 28, 1988
Order of Dismissal

Claimant has requested review of Referee Livesley's Order Denying Reconsideration. We have reviewed the request to determine whether we have jurisdiction to consider the matter. We conclude that we lack jurisdiction.

FINDINGS

On January 8, 1988, the Referee issued an order dismissing claimant's request for hearing. On April 27, 1988, claimant requested reconsideration of the dismissal order, asking that the dismissal order be set aside and that a hearing be scheduled.

On May 5, 1988, the Referee issued an "Order Denying Reconsideration." After reviewing the case's procedural history, the Referee declined to grant claimant's request for rescission of the dismissal order.

On June 3, 1988, the Board received claimant's request for review of the Referee's May 5, 1988 order. The request indicated that copies of the request had been provided to the other parties to the proceedings.

The Referee's January 8, 1988 dismissal order was neither abated, withdrawn, stayed, republished, modified, nor appealed within 30 days of its issuance.

CONCLUSIONS

A Referee's order is final unless, within 30 days after the date on which a copy of the order is mailed to the parties, one of the parties requests Board review under ORS 656.295. ORS 656.289(3). The time within which to appeal an order continues to run, unless the order has been "stayed," withdrawn, or modified. International Paper Co. v. Wright, 80 Or App 444 (1986); Fischer v. SAIF, 76 Or App 656, 659 (1986). In order to abate and allow reconsideration of an order issued under ORS 656.289(1), at the very least, the language of the second order must be specific. Farmers Insurance Group v. SAIF, 301 Or 612, 619 (1986).

Here, claimant has requested review of the Referee's May 5, 1988 Order Denying Reconsideration within 30 days of its issuance. Yet, the May 5, 1988 order issued more than 30 days after the January 8, 1988 dismissal order. Moreover, the January 8, 1988 order was neither abated, withdrawn, stayed, modified, nor republished prior to the issuance of the May 5, 1988 order.

Inasmuch as the 30-day statutory appeal period from the January 8, 1988 order has elapsed unabated without a timely request for review, it has become final by operation of law. See ORS 656.289(3); International Paper Co. v. Wright, supra; Farmers Insurance Group v. SAIF, supra. Furthermore, since the January 8, 1988 dismissal order has become final, the Referee lacked jurisdiction to issue the May 5, 1988 order. See ORS 656.289(3); International Paper Co. v. Wright, supra; Farmers Insurance Group v. SAIF, supra. Thus, the May 5, 1988 order is a nullity.

Based on the foregoing reasoning, we conclude that we lack jurisdiction to consider claimant's request for Board review of either the January 8, 1988 Order of Dismissal or the May 5, 1988 Order Denying Reconsideration. See Maria C. Mendoza, 40 Van Natta 499 (May 25, 1988). Accordingly, the request for review is dismissed.

IT IS SO ORDERED.

CATHEY M. DAVIDSON, Claimant
Daryll E. Klein, Claimant's Attorney
Schwabe, et al., Defense Attorneys
Thomas Sheridan (SAIF), Defense Attorney
Ann Kelley, Assistant Attorney General

WCB 86-17404 & 86-08865
June 28, 1988
Order on Review

Reviewed by Board Members Crider and Ferris.

SAFECO Insurance Company requests review of those portions of Referee T. Lavere Johnson's order that: (1) set aside its denial of claimant's current low back condition; and (2) affirmed a Determination Order that set aside its Notice of Closure. The Determination Order found that claimant's condition was disabling and stated that the claim remained open. On review, SAFECO argues that claimant's current low back condition is not compensable, and, if it is compensable, that the SAIF Corporation is responsible for the condition. We affirm.

ISSUES

1. Propriety of the March 6, 1987 Determination Order.

2. Whether SAFECO's denial dated January 22, 1987 is procedurally improper; and

3. Alternatively, compensability of, and responsibility for, claimant's current low back condition as between SAIF, which was on the risk at the time of her October 5, 1984 injury, and SAFECO, which was on the risk at the time of her March 6, 1985 injury.

FINDINGS OF FACT

The Board affirms and adopts the Referee's Findings of Fact, supplemented as follows.

Claimant began to experience radiating pain to her right leg in August 1985.

CONCLUSIONS OF LAW AND OPINION

Propriety of the March 6, 1987 Determination Order

The Referee upheld the March 6, 1987 Determination Order that found claimant's March 6, 1985 injury to be disabling and stated that the claim remained open. The Board affirms and adopts the Referee's conclusions on this issue.

Propriety of SAFECO's January 22, 1987 Denial

The Referee set aside SAFECO's January 22, 1987 denial on the basis that it was an impermissible "backup" denial pursuant to Bauman v. SAIF, 295 Or 788 (1983). Under Bauman, an insurer may not retroactively deny the compensability of a claim more than 60 days after notice of the claim. On review, SAFECO argues that it may issue a denial of a previously accepted claim so long as the claim has been closed. However, as held above, the March 6, 1987 Determination Order properly found that the claim for the March 6, 1985 injury remained open.

Moreover, SAFECO sought by its denial to extinguish claimant's right to continuing care for an inseparable condition before the claim was ready for closure. This violates the rule established by the Court of Appeals in Roller v. Weyerhaeuser Co., 67 Or 583, adhered to as amplified 68 Or App 743, rev den 297 Or 601 (1984). Under Roller, once an insurer has accepted a medical condition it may not deny all medical services related to the claim, prior to closure. Under the facts of this case, SAFECO is precluded from attempting to deny any and all benefits subsequent to March 14, 1985.

The Referee also concluded that SAFECO was precluded from denying the claim pursuant to res judicata principles. See North Clackamas School Dist. v. White, 305 Or 48 (1988). Our decision above renders consideration of the res judicata issue unnecessary.

In conclusion, we find that SAFECO's denial is procedurally improper. However, assuming that SAFECO's denial was not procedurally impermissible, we address the merits of the compensability and responsibility issues.

Compensability

In support of its compensability argument, SAFECO relies upon a statement by Dr. Waldram that it was possible that claimant's low back condition was not related to either injury. Waldram's reasoning was that claimant's low back complaints did not appear until more than two months following the first injury. He further opined that back pain is extraordinarily common and cannot always be attributed to a specific cause or event.

We find this reasoning unpersuasive. We note that claimant had no back problems prior to October 1984. Furthermore, there was no evidence of any intervening events between the October 1984 injury and the onset of her low back problems. We conclude that claimant has sustained her burden on the compensability issue.

Responsibility

The Referee found that SAFECO, rather than SAIF, was responsible for claimant's compensable condition. We agree.

SAFECO argues that claimant's March 1985 injury caused only a temporary aggravation of her condition. SAFECO notes in this regard that claimant did not report right leg symptoms until five months after her March injury. We acknowledge that claimant did not experience the onset of right leg symptoms contemporaneously with the March 1985 injury. However, we do not find this fact dispositive of the issue before us.

Turning to the medical evidence, Dr. Waldram testified at deposition that he could not say, in terms of medical probability, that either the October 1984 or the March 1985 incident contributed to claimant's ongoing condition. Dr. Waldram's opinion on this question is, therefore, inconclusive.

Portions of Dr. Kennedy's testimony support a material contribution resulting from the March 1985 injury. For example, Dr. Kennedy was aware that claimant's right leg problems did not appear until August 1985, and yet he opined that the appearance of these problems would lead him to "suspect" that the March 1985 fall aggravated claimant's underlying condition. Dr. Kennedy also opined that claimant's reported history would indicate a worsening of her condition. On the other hand, Dr. Kennedy stated that he was unable to attribute claimant's chronic fibrositis to one injury or the other. Consequently, Dr. Kennedy's opinions are not entirely consistent, although, considered as a whole, they preponderate in favor of a material contribution to claimant's current condition from the March 1985 incident.

In terms of further evaluating Dr. Kennedy's persuasiveness, we note that he did not examine claimant until approximately two years after her March 1985 fall. Further, he stated that he had not reviewed the records of claimant's treating physicians at the time of her injuries. In addition, Dr. Kennedy mistakenly believed that claimant was off work from March 6, 1985 until August 1985. As a consequence, the persuasiveness of his opinions is further diminished. Georgia-Pacific Corp. v. Roff, 80 Or App 78, 82 (1986).

In sum, we find that Dr. Waldram expresses no opinion as to whether claimant's March 1985 injury contributed to her current condition. Dr. Kennedy opines that there was a contribution from the March 1985 injury, but his opinions are inconsistent and largely unpersuasive.

A rebuttable presumption exists that a claimant's last industrial injury contributed independently to claimant's condition. Industrial Indemnity Co. v. Kearns, 70 Or App 583, 587 (1984); Rebecca J. Ferolin, 39 Van Natta 754, 756 (1987). SAFECO, the insurer on the risk at the time of claimant's most recent injury, has failed to show that there is no causal connection between claimant's post-March 14, 1985 condition and the March 6, 1985 accident. Therefore, even if SAFECO's denial was not procedurally improper, it is nonetheless substantively incorrect. SAFECO is responsible for payment of claimant's compensation.

We cannot approve a client-paid fee unless SAFECO's

counsel files a statement of services. See OAR 438-15-010(5). Because no statement of services has been received to date, a client-paid fee shall not be authorized.

ORDER

The Referee's order dated October 13, 1987 is affirmed. Claimant's attorney is awarded an assessed fee of $400, to be paid by SAFECO.

DEBORAH S. ERICKSON, Claimant
David J. Hollander & Assoc., Claimant's Attorneys
Schwabe, et al., Defense Attorneys

WCB 86-15003
June 28, 1988
Order on Review

Reviewed by Board Members Crider and Ferris.

Claimant requests review of Referee Lipton's order which upheld the insurer's partial denial of her medical services claim for a condition involving her neck, left shoulder and arm. We affirm.

ISSUES

1. Whether medical services for neck, shoulder and arm symptoms are compensable.

2. Whether those services are reasonable and necessary.

FINDINGS OF FACT

We adopt the Referee's findings of fact with the following supplementation. In late 1976 or early 1977, claimant sustained a compensable, nondisabling injury which was diagnosed as a lumbosacral sprain/strain with thoracocervical myofascitis. Her symptoms were initially limited to numbness and "burning" in the left shoulder, but later included headaches, low back pain and numbness, numbness near the left scapula, and radiating pain and numbness in the left arm and hand. She underwent physical therapy and treated conservatively with several physicians through November 1982.

From November 1982 to April 1984, claimant did not seek medical care, though she continued to experience left shoulder pain and left scapular numbness. On April 20, 1984, claimant was involved in a car accident in which she was rear-ended. Several days later, she saw Dr. Stevko, a chiropractor, with headaches and neck pain. Stevko diagnosed acute cervicothoracic strain/sprain with subluxation of C5 and T4. That injury resolved by July 10, 1984 with no residual disability. Stevko's notes during this period of treatment bore no mention of claimant's compensable injury in 1976/1977.

Two years later, in July 1986, claimant returned to Dr. Stevko with severe neck and middle back pain radiating into the left shoulder and arm. These symptoms developed approximately two days after claimant had painted her kitchen ceiling with her head held in hyperextension. The symptoms were so severe that Stevko initially treated claimant at home. The severe pain resolved four weeks later, but claimant continued to treat with Stevko for neck, middle back, left shoulder and arm symptoms which Stevko attributed to the compensable injury in 1976/1977.

On October 9, 1986, the insurer denied benefits for medical services provided by Dr. Stevko, which began in July 1986.

At the time of hearing on June 25, 1987, claimant continued to experience pain and numbness near her left scapula. She had not received any medical treatment during the two months preceding the hearing.

We are unable to find that Dr. Stevko's treatment has provided any material benefit in alleviating the numbness and "burning" near claimant's left scapula. We are also unable to find that the compensable injury materially contributed to claimant's need for treatment of her remaining symptoms in the neck, middle back, left shoulder and arm.

CONCLUSIONS AND OPINION

The Referee upheld the insurer's partial denial, concluding that Dr. Stevko's treatment was either not related to to the compensable injury or not reasonable and necessary. We agree.

The insurer must provide medical services for conditions resulting from a compensable injury for so long as the nature of the injury or the process of the recovery requires. ORS 656.245(1). There are two prerequisites to claimant's entitlement to these services. First, she must establish the compensability of those services by proving that the compensable injury materially contributed to her need for treatment. See Hutcheson v. Weyerhaeuser, 288 Or 51, 56 (1979); Milburn v. Weyerhaeuser Company, 88 Or App 375, 378 (1987). Second, she must prove that the treatment itself was reasonable and necessary. See James v. Kemper Ins. Co., 81 Or App 80, 81 (1986).

Compensability

At the outset, we note the undisputed fact that claimant has experienced continual numbness and some "burning" near the left scapula since the compensable injury. That fact alone persuades us that those particular symptoms were related to the injury.

With regard to the other symptoms, however, the evidence is not so persuasive. Only Dr. Stevko, the treating physician, related all of the symptoms to the compensable injury. Stevko reasoned that claimant had suffered no additional trauma since the compensable injury, that the injury from the car accident had been resolved for two years, and that her recent symptoms were located in the same region as the numbness and "burning" near the left scapula. Stevko explained that the compensable injury was of the type that causes instability in the supporting joint, ligamentous, and muscular structures, increasing their susceptibility to further aggravation.

Contrary opinions were offered by Dr. Duncan, a chiropractor who conducted an independent medical examination (IME) in October 1986, and Dr. Snodgrass, a neurologist who had cared for claimant in late 1981 and examined her again in January 1987. Duncan attributed her symptoms and continuing treatment to muscular tension resulting from nervousness. Duncan doubted that the compensable injury had remained symptomatic during the

previous 10 years. Dr. Snodgrass also felt that Stevko's treatment was not related to the compensable injury, opining instead that it was related to separate subsequent injuries.

When medical evidence is divided, we tend to give greater weight to the conclusions of the treating physician, absent persuasive reasons not to do so. Weiland v. SAIF, 64 Or App 810, 814 (1983). We find persuasive reasons not to do so here.

Dr. Stevko failed to attribute any significance to the painting incident in July 1986, despite the fact that claimant's symptoms after the incident were more severe than any she had experienced after the compensable injury. Whereas claimant missed no time from work after the compensable injury, after the painting incident she was unable to lift her head off her pillow and required home treatment. Indeed, claimant herself thought that she had suffered another strain. In addition, the symptoms resulting from the painting incident were located in the same region as those symptoms which Stevko later attributed to the compensable injury. Dr. Stevko's failure to address, much less distinguish, the painting incident and resulting symptoms renders her opinion less persuasive.

Dr. Stevko's opinion is further discounted for its speculative nature. In relating claimant's recent symptoms to the compensable injury, Stevko noted that they were located in the same region as the left scapular numbness and "burning." Yet, Stevko has never explained the relationship between the scapular symptoms, which were related to the compensable injury, and the symptoms involving the neck, middle back, left shoulder and arm. Their shared location suggests a compensable relationship, but that is simply too speculative to sustain claimant's burden of proving compensability.

Dr. Snodgrass, on the other hand, discussed the painting incident adequately and concluded that Stevko's treatment was not related to the compensable injury, but rather, was related to the subsequent injuries. His conclusion was further bolstered by that of Dr. Duncan. We are persuaded primarily by Dr. Snodgrass' thorough and well-reasoned reports and find that the compensable injury did not materially contribute to claimant' recent symptoms in the neck, middle back, left shoulder and arm. See Somers v. SAIF, 77 Or App 259, 263 (1986). Consequently, treatment for those symptoms was not compensable.

Reasonable and Necessary

Although the numbness and "burning" near claimant's left scapula was related to the compensable injury, we find that Dr. Stevko's treatment provided no material benefit in alleviating those symptoms. Stevko conceded in February 1987 that no treatment would eliminate those symptoms. In addition, there is no evidence to support Stevko's assertion that her treatment has alleviated those symptoms to any degree. Indeed, those symptoms persisted to the time of hearing. Stevko has never explained the etiology or significance of those symptoms. Given the lack of material benefit, we conclude that Stevko's treatment of those symptoms was neither reasonable nor necessary.

ORDER

The Referee's order dated July 2, 1987 is affirmed. The Board approves a client-paid fee not to exceed $1,530.

HERBERT D. MINDT, Claimant
Philip H. Garrow, Claimant's Attorney
Joseph McNaught (SAIF), Defense Attorney

WCB 87-13295
June 28, 1988
Order on Review

Reviewed by Board Members Ferris and Crider.

Claimant requests review of that portion of Referee Higashi's order which upheld the SAIF Corporation's denial of his claim for a neck and left shoulder injury. The sole issue is compensability.

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

FINDING OF FACT

There was insufficient evidence to support a finding that claimant sustained a neck and left shoulder injury at work in November or December of 1986.

CONCLUSION AND OPINION

We find claimant not credible, based on inconsistencies in the documentary evidence of his history of the alleged industrial injury. Lacking sufficient independent corroboration of claimant's history of the injury, we are unable to find that he sustained the injury at work in November or December of 1986. We conclude, therefore, that his claim was not compensable.

ORDER

The Referee's order dated December 14, 1987 is affirmed.

THELMA T. SMARTT, Claimant
Malagon & Moore, Claimant's Attorneys
Jeff Gerner (SAIF), Defense Attorney

WCB 86-11704
June 28, 1988
Order on Review

Reviewed by Board Members Crider and Ferris.

The SAIF Corporation requests review of that portion of Referee Garaventa's order which found that it had miscalculated the rate of claimant's temporary total disability compensation. Claimant makes no formal cross-requests, but moves to strike SAIF's opening brief as untimely served on claimant's attorney.

We reverse that portion of the Referee's order requiring SAIF to pay temporary disability compensation based on claimant's rate of pay as of her March 14, 1986 performance review.

ISSUES

1. Motion to Strike
2. Temporary Total Disability

FINDINGS OF FACT

Claimant, who was 61 at the time of hearing, filed a claim on July 17, 1986 for occupational stress. At the time, she was employed as a business services supervisor, charged with the supervision of clerical personnel.

Beginning in early 1986, there had been rumors of an

impending lay-off at her place of employment. On May 14, 1986, claimant had her work performance reviewed and received a poor evaluation. Claimant characterized the result as "totally unexpected" and unjustified. Yet, she was unable to submit a rebuttal within the time limitation for the processing of evaluations. Claimant was "[d]evastated" and fearful of a demotion and reduction in salary and benefits. Although able to maintain her composure at work, she was a "mess" at home.

In mid-June 1986, claimant learned that her position would be eliminated. She was offered the option of either being laid off or demoted. She elected a demotion, hoping to become an administrative assistant. Instead, she was assigned to a clerical specialist position.

The demotion took effect on July 1, 1986. Although claimant's responsibilities remained essentially the same, her salary, social security, and retirement benefits were reduced.

On July 8, 1986, claimant was asked to attend a clerical staff meeting. She attended the meeting but asked for the rest of the day off. Feeling at her "wits' end," claimant sought medical services the following day. She did not return to work, but instead filed a claim for "mental-emotional stress" on July 10, 1986. Her claim was apparently accepted as an occupational disease and her temporary total disability compensation was calculated on the basis of her salary on July 9, 1986, the date she became disabled.

In an accident report, claimant explained to her supervisor that she attempted to adjust to the employer's decision to demote and reassign her, but found that the "totality of the results (financial and professional)" had overwhelmed her coping skills. She indicated that she was physically and emotionally unable to carry on.

Dr. Herbert Baker, claimant's treating physician, diagnosed acute situational depression directly related to her demotion and job-related stress. He also noted claimant's history of chronic obstructive pulmonary disease and heart disease with old anterior myocardial infarction and ventricular tachycardia as a complication.

We find that the stress condition worsened gradually from the time of the performance review to claimant's eventual demotion on July 1, 1986.

On Board review, SAIF timely filed its brief on May 29, 1987. However, SAIF served the copy of the brief on an attorney unrelated to this claim. That attorney then forwarded the copy to claimant's attorney on June 9, 1987. Claimant timely filed her respondent's brief, which specifically addressed the arguments raised in SAIF's brief.

CONCLUSIONS AND OPINION

Motion to Strike

Our rules of procedure do not specifically provide that a brief not served on all other parties may be stricken. See former OAR 438-11-035(2). However, we conclude that such a remedy is implied and within our discretion. David F. Weich, 39 Van Natta 468 (1987); James M. Kleffner, 38 Van Natta 1413 (1986).

Here, claimant has not been prejudiced by SAIF's failure to comply fully with our rules of procedure. Therefore, we deny her motion to strike.

Temporary Total Disability

On the merits, the Referee found that the May 14 evaluation materially contributed to her disability. Consequently, the Referee reasoned that claimant's stress claim should have been processed as an accidental injury. The Referee therefore concluded that temporary total disability compensation should be based on claimant's salary on May 14, 1986 the designated date of injury, rather than July 9, 1986, the date of disability. We disagree.

Temporary total disability compensation is calculated as a percentage of claimant's wages. ORS 656.210(1). In accidental injury cases, the relevant "wages" are those being received by claimant at the time of injury. Former ORS 656.210(2). Consequently, if claimant's stress claim is for an accidental injury, her temporary total compensation shall be calculated as a percentage of her wage on May 14, 1986, the date of the performance review.

On the other hand, former Chapter 656 included no express provision for ascertaining the wage upon which to base temporary total disability benefits in occupational disease cases. We previously filled that gap in legislation in Joseph A. Reznicsek, 36 Van Natta 1361 (1984), where we concluded that benefits shall be based on the wage received on the date of the last injurious exposure. In this context, the date of last injurious exposure is the date of the last event providing potentially causal conditions for the occupational disease. Compare Boise Cascade v. Starbuck, 296 Or 238, 241 (1984) (In successive employment context, the "last injurious exposure" is the critical event in assigning liability for occupational disease among multiple employers).

As an aside, we note that the 1987 legislature has overturned Reznicsek to provide that benefits be based on the wage at the time of disability. See Or Laws 1987, ch 713, § 7. However, that provision took effect on January 1, 1988 and does not apply here.

Here, claimant's demotion on July 1, 1986 was a potentially causal contributor to her stress reaction. Dr. Wadley, the consulting psychiatrist, attributed most of claimant's emotional reaction to the financial loss caused by the demotion. The accident report also reflects that claimant was unable to cope with the financial and professional setbacks of demotion. We are persuaded that the decrease in claimant's salary and benefits, while her responsibilities remained essentially the same, could have induced her stress condition. Consequently, if claimant's stress claim is for an occupational disease, her temporary total disability compensation shall be calculated as a percentage of her wage on July 1, 1986, the date of demotion.

The dispositive issue, therefore, is whether claimant's stress claim is for an accidental injury or an occupational disease. The Supreme Court faced precisely this issue in James v. SAIF, 290 Or 343 (1980). The claimant in James was publicly and heatedly reprimanded by her supervisor. These encounters caused

claimant to become increasingly nervous and take large quantities of a tranquilizer. Six months after the initial reprimand, claimant felt unable to go to work and sought psychiatric treatment. She was diagnosed as suffering from anxiety and depression neuroses which were caused by or exacerbated by her supervisor's conduct.

The Court distinguished occupational diseases from accidental injuries in two ways: (1) occupational diseases are not unexpected in that they are recognized as an inherent hazard of continued exposure to conditions of the particular employment; and (2) they are gradual rather than sudden in onset. Id. at 348. Applying the forgoing distinction, the Court held that claimant's mental condition was an occupational disease, finding that: (1) her condition was not unexpected in light of her prior history of developing neuroses in response to criticism; and (2) her condition developed gradually over the course of six months.

The Court of Appeals later construed the "sudden in onset" language in James, supra, to mean occurring during a short, discrete period, rather than over a long period of time. Valtinson v. SAIF, 56 Or App 184, 188 (1982).

The "injury-disease" distinction was reexamined in Donald Drake Co. v. Lundmark, 53 Or App 261 (1983), rev den 296 Or 350 (1984). The claimant in Lundmark developed back pain over a six-week period while operating a defective front-end loader. The court held that claimant's back condition was an injury rather than an occupational disease. In so holding, the court found that claimant's condition was unexpected, because he had operated similar equipment for eight years without any back problems. Although the claimant's condition worsened over a six-week period, the court further found that his condition nevertheless satisfied the "sudden in onset" requirement because it coincided precisely with an identifiable event that caused his disability, i.e., the traumatic jolting of the faulty loader.

We now apply the forgoing analysis to the instant facts. Claimant has a history of various physical illnesses which, according to Dr. Wadley, contribute to her emotional lability, implying a "generalized, vulnerability both physically and psychologically brought upon through chronic stresses, particularly in her job, probably with her children, also implying inability to cope with ongoing stresses, especially as severe as this one is." Given her psychological vulnerability and inability to cope with ongoing stresses, we find that claimant's stress condition was not unexpected.

In addition, the seven-week lapse of time between the work evaluation and the date of disability suggests a gradual, rather than sudden, development in her condition. Unlike Lundmark, supra, claimant's stress condition did not coincide with a particular, identifiable event. Rather, there was a series of events which led to her disability: (1) the May 14 work evaluation; (2) her discovery in mid-June that she would not be demoted to her preferred position as administrative assistant; and (3) her eventual demotion with attendant salary reduction.

Claimant testified that her condition did not worsen after the May 14 work evaluation. We find her testimony unpersuasive, particularly since she neither became disabled nor sought medical treatment until seven weeks after the evaluation.

We consider these facts to be similar to those present in James, supra, where a series of stress-inducing criticisms and demands contributed to claimant's mental condition which eventually rendered her unable to work. We therefore conclude that SAIF properly processed claimant's stress claim as an occupational disease.

ORDER

The Referee's order dated March 9, 1987 is affirmed in part and reversed in part. We reverse that portion of the order which increased the rate of claimant's temporary total disability compensation and allowed an attorney fee payable out of the increased award. The remainder of the Referee's order is affirmed.

JOHN G. SWOYER, Claimant
Roger Wallingford, Claimant's Attorney
Carrol Smith (SAIF), Defense Attorney

WCB 87-03647
June 28, 1988
Order on Review

Reviewed by Board Members Ferris and Johnson.

Claimant requests review of Referee Thye's order that approved a stipulation, on the record, that all issues raised or raisable at hearing were resolved upon the terms and conditions set forth in the Referee's order. Claimant contends that this matter should be remanded to determine if he understood the terms of the stipulation.

We may remand to the Referee should we find that the record has been "improperly, incompletely or otherwise insufficiently developed." ORS 656.295(5). After de novo review, we find that the record is not silent concerning the events surrounding the execution of the stipulation. Accordingly, claimant's request for remand is denied.

We affirm the Referee's order.

ORDER

The Referee's order dated June 2, 1987 is affirmed.

JANICE G. THON, Claimant
Merrill Schneider, Claimant's Attorney
Carroll Smith (SAIF), Defense Attorney

WCB 85-00402
June 28, 1988
Order on Review

Reviewed by Board Members Crider and Johnson.

The SAIF Corporation requests review of that portion of Referee Knapp's order that: (1) set aside its partial denial of claimant's psychological condition as an impermissible "backup" denial under Bauman v. SAIF, 295 Or 788 (1983); and (2) awarded claimant's attorney an extraordinary attorney fee of $3,500 for services at hearing. In her brief, claimant requests an increase in penalty and attorney fee for late payment of medical bills. On review, the issues are compensability, penalties and attorney fees. We affirm in part and modify in part.

Findings of Fact

We adopt the Referee's findings of fact on Pages 1 through 8, and the first two lines of Page 9, of the Opinion and Order, and supplement them as follows.

At the time of hearing, claimant was a patient at a hospital, under the care of Dr. Dixson, psychiatrist. He treated her from October 1986 on, and diagnosed major depression related to her 1980 occupational disease. We find that claimant suffered from a major depression which was caused in material part by the compensable disease. Other factors in her depression were her inability to complete her chosen college program and her inability to provide for herself, both a result of her disease.

Conclusions of Law and Opinion

The Referee found that claimant's psychological condition was compensable, both because SAIF had accepted the condition by its May 7, 1985 letter, and because her compensable right elbow condition was a material contributing cause for the onset of her subsequent psychological disability.

The letter in question reads in pertinent part:

> "We have reviewed all information regarding the worsening of your condition and have reopened your claim."

Under current case law, it is possible to read SAIF's letter as accepting claimant's psychological condition. See Georgia-Pacific Corp. v. Piwowar, 305 Or 494 (1988); Johnson v. Spectra Physics, 303 Or 49 (1987); Bauman v. SAIF, 295 Or 788 (1983). We need not decide the point, however, because we agree with the Referee that claimant's compensable injury materially contributed to her current psychological condition.

Claimant has proven that her right elbow condition was a material factor in her need for psychiatric treatment, which is a worsening of her preexisting psychological condition. The court has held that, in the absence of a satisfactory medical explanation of a distinction between symptoms and the condition, mental conditions have worsened when their symptoms have worsened. SAIF v. Varner, 89 Or App 421 (1988); Adsitt v. Clairmont Water District, 79 Or App 1 (1986).

Claimant has been diagnosed as having borderline personality disorder, which develops during childhood and is established by adulthood. Thus, claimant's psychological condition preexisted her right elbow condition. However, it was asymptomatic or nondisabling before her elbow condition developed. The doctors, psychiatrists and psychologists who have examined claimant attribute her depression and suicidal tendencies primarily to her borderline personality disorder, as well as to her abuse of marijuana, her family history, and her multiple physical ailments. Among those physical ailments is her elbow condition, and it was her elbow condition which led to her unemployment, which in turn led to depression and suicide attempts.

Dr. Klein and Dr. Paulsen feel that claimant's psychological condition is not related to her 1980 injury because that injury is not her major problem. The test is not whether the injury is her major problem, but whether it is a material contributing factor in her psychological condition. We are persuaded by the majority of medical opinion, and conclude that it was a material contributing factor in the onset of her disabling psychological symptoms. See also Grace v. SAIF, 76 Or App 511 (1985); Jeld-Wen v. Page, 73 Or App 136 (1985).

The Referee awarded claimant an attorney fee of $3,500 for setting aside SAIF's denial. At the time, OAR 438-47-015 provided the Referee with discretion to award an attorney fee of up to $3,000 on a denied claim ordered accepted by the Referee. The Referee was allowed discretion to award a fee in excess of the rule's maximum when claimant's attorney provided a sworn statement regarding the services rendered on claimant's behalf, and the services were deemed to have been extraordinary. See former OAR 438-47-010(2). This case factually and legally is complex. We affirm the Referee's award of an extraordinary fee.

Finally, the Referee awarded claimant a penalty and attorney fee for late payment of medical bills of 3 percent of the amount of the late payments and $400, respectively. We have considered the relevant factors on this issue, and affirm the award of the Referee.

ORDER

The Referee's order dated July 10, 1987 is affirmed. Claimant's attorney is awarded an assessed fee of $500, to be paid by the SAIF Corporation.

MARCIA M. McKELLIPS, Claimant
Pozzi, et al., Claimant's Attorneys
Nelson, et al., Defense Attorneys

WCB 86-11056
June 29, 1988
Amended Order of Dismissal

On June 16, 1988, in accordance with the insurer's withdrawal of its request for review, we issued our Order of Dismissal. Claimant has requested an insurer-paid attorney fee for prevailing against the insurer's appeal of the Referee's order.

The request for an attorney fee is denied. Where an insurer's or employer's request for Board review is dismissed prior to a decision on the merits, claimant is not entitled to an attorney fee. 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).

Accordingly, our June 16, 1988 order is withdrawn. As supplemented herein, we adhere to and republish our June 16, 1988 order, effective this date.

ROBERT L. REYES, Claimant
Bloom, et al., Claimant's Attorneys
Bottini, et al., Defense Attorneys
Williams, Zografos & Peck, Defense Attorneys

WCB 86-08493 & 86-09981
June 29, 1988
Order on Reconsideration

Claimant has requested reconsideration of our Order on Review dated December 18, 1987, that declined to award an attorney fee in a case involving the issue of responsibility. On January 15, 1988, the Board's order was abated and Fireman's Fund Insurance Company and Safeco Insurance Company were granted an opportunity to respond. Having received the insurers' responses, the Board has reconsidered the matter.

The issue of responsibility for claimant's back condition proceeded to hearing after the issuance of an ORS 656.307 order. The Referee set aside Fireman's Fund's denial of claimant's aggravation claim and upheld Safeco's denial of

claimant's "new injury" claim. Fireman's Fund requested Board review and we affirmed the Referee's order, but declined to award an attorney fee for claimant's attorney's services on review. On reconsideration, claimant's attorney argues that he is entitled to a fee for time expended "on the merits before the Board . . . ." We agree.

At the hearing, claimant took the position and actively litigated the point that he had sustained an aggravation, rather than a "new injury." See Petshow v. Farm Bureau Ins. Co., 76 Or App 563, 569 rev den 300 Or 722 (1986). Claimant's stake in the outcome of that determination centered upon increased temporary disability benefits. See SAIF v. Phipps, 85 Or App 436, 439 (1987). On Board review, in response to Fireman's Fund's contentions, claimant continued to take the position that he had sustained an aggravation.

Accordingly, we find that claimant's attorney is entitled to a reasonable assessed fee of $750 for his services on Board review, to be paid by Fireman's Fund Insurance Company. ORS 656.382(2); see OAR 438-15-005(2).

On reconsideration, as modified herein, we adhere to and republish our former order, effective this date.

IT IS SO ORDERED.

BRYAN D. WARRILOW, Claimant
Doblie & Associates, Claimant's Attorneys
Schwabe, et al., Defense Attorneys

WCB 86-09029
June 29, 1988
Order on Reconsideration

The self-insured employer requests reconsideration of our June 2, 1988 Order on Review that set aside its partial denial of claimant's current neck condition, identified as "mild degenerative changes with mild osteophytic spurring," as procedurally improper. Specifically, the employer contends that: (1) we misinterpreted the Supreme Court's decision in Johnson v. Spectra Physics, 303 Or 49 (1987) concerning the acceptance of claims and the issuance of partial denials; or alternatively, (2) because our rationale in setting aside the partial denial is "entirely new," this matter should be remanded to the Referee for the taking of additional evidence.

We may remand to the Referee should we find that the record has been "improperly, incompletely or otherwise insufficiently developed." ORS 656.295(5). To merit remand, it must be established that the evidence relevant to the issues raised in the request to remand 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).

After conducting our review, we are not persuaded that this record has been either "improperly, incompletely or otherwise insufficiently developed." Furthermore, the employer has failed to establish that the evidence to be offered on remand was unobtainable with due diligence before the hearing. Consequently, the request to remand is denied.

Accordingly, the employer's request for reconsideration is granted and our prior order withdrawn. On reconsideration, as supplemented herein, we adhere to and republish our June 2, 1988 order, effective this date. A client-paid fee, not to exceed $1,394.50, is approved for services rendered on Board review.

ROBERT D. BURNS, Claimant
Cowling & Heysell, Claimant's Attorneys
Luvaas, Cobb, et al., Defense Attorneys

WCB 86-12488
May 12, 1988
Order of Abatement

The Board has received the insurer's motion for reconsideration of our Order on Review dated April 29, 1988.

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

IT IS SO ORDERED.

LEONARD A. CHAMBERS, Claimant
Doblie & Associates, Claimant's Attorneys
Roberts, et al., Defense Attorneys

WCB 87-03511
April 19, 1988
Order of Abatement

The insurer requests reconsideration of the Board's Order on Review dated March 24, 1988. In order to allow sufficient time to consider the request, we withdraw and abate our Order on Review effective this date. Claimant is allowed 14 days from the date of this order within which to file a response.

IT IS SO ORDERED.

CAROL A. FISHER, Claimant
Pozzi, et al., Claimant's Attorneys
Roberts, et al., Defense Attorneys
James Griffin, Assistant Attorney General

WCB 87-15218 & 87-12543
June 17, 1988
Order of Abatement

The SAIF Corporation requests reconsideration of the Board's Order on Review dated May 18, 1988. It contends that the Board erred in: (1) deciding the case on an industrial injury theory because the parties litigated the case on an occupational disease theory; (2) characterizing claimant's claim as one for industrial injury rather than one for occupational disease; and (3) concluding that the medical evidence was sufficient to establish the compensability of claimant's claim even on an industrial injury theory. To provide sufficient time to consider the request, we withdraw and abate our Order on Review in this case, effective this date. Claimant is allowed 14 days from the date of this order in which to respond. Thereafter, we shall take this matter under advisement.

IT IS SO ORDERED.

SHERMAN V. GRIFFITH, Claimant
Tharp & Van Atta, Claimant's Attorneys
Davis, et al., Defense Attorneys
Schwabe, et al., Defense Attorneys

WCB 85-11244, 85-05496 & 85-08267
April 15, 1988
Order of Abatement

On March 24, 1988, we issued an Interim Order of Remand, referring this matter to the Referee with instructions to reconvene a hearing. Our action was prompted by the hearing reporter's failure to provide a transcript of the parties' previous hearing.

Since the issuance of our order, the Board has received a partial hearing transcript concerning another longstanding case involving this same hearing reporter. In addition, the reporter has assured the Board that the transcript in this case will soon be forthcoming.

The Board's receipt of the entire transcript of the prior hearing will obviate the need for a new hearing. Considering the aforementioned recent events, we conclude that a new hearing may not be required. Therefore, we direct that a new hearing date in this case not be scheduled.

Accordingly, our March 24, 1988 Interim Order of Remand is abated and withdrawn. We shall continue to closely monitor this matter and keep the parties fully advised of further developments in this case.

IT IS SO ORDERED.

CLAUDE E. HARRIS, Claimant
Angelo Gomez, Claimant's Attorney
Roberts, et al., Defense Attorneys

WCB 87-16670
May 5, 1988
Order of Abatement

Claimant has requested reconsideration of our April 8, 1988 Dismissal Order. He encloses affidavits in support of his contention that he timely mailed his request for review to the Board, as well as timely provided notice of his request to the insurer's counsel.

In order to allow sufficient time to consider the request, the above noted Board order is abated and the insurer is asked to respond to the request within 14 days. Thereafter, we shall take this matter under advisement.

IT IS SO ORDERED.

RICHARD R. INGALLS, Claimant
Pozzi, et al., Claimant's Attorneys
SAIF Corp Legal, Defense Attorney

WCB 86-03202
April 15, 1988
Second Order of Abatement

On March 24, 1988, we issued a Second Interim Order of Remand, referring this matter to the Referee with instructions to reconvene a hearing. Our action was prompted by the hearing reporter's failure to provide a transcript of the parties' previous hearing.

Since the issuance of our order, the Board has received a partial transcript of the previous hearing. In addition, the reporter has assured the Board that the remaining portion of the transcript will soon be forthcoming.

The Board's receipt of the entire transcript of the prior hearing will obviate the need for a new hearing. Considering the aforementioned recent events, we conclude that a new hearing may not be required. Therefore, the hearing date, currently scheduled for June 1, 1988, is cancelled.

Accordingly, our March 24, 1988 Second Interim Order of Remand is abated and withdrawn. We shall continue to closely monitor this matter and keep the parties fully advised of further developments in this case.

IT IS SO ORDERED.

HARRY A. JOERS, Claimant
Roll, et al., Claimant's Attorneys
Acker, Underwood, et al., Defense Attorneys
Davis, et al., Defense Attorneys

WCB 86-16915 & 86-14634
April 19, 1988
Order of Abatement

Farmers Insurance Group has requested reconsideration of our Order on Review dated March 21, 1988. In order to allow time for Liberty Northwest Insurance Corporation and claimant to respond and for the Board to consider the request, our Order on Review is abated and withdrawn, effective this date. Liberty Northwest and claimant are each allowed 14 days from the date of this order in which to file their respective responses. Thereafter, this matter shall be taken under advisement.

IT IS SO ORDERED.

FRANKIE L. McDONALD, Claimant
Gary J. Susak, Claimant's Attorney
Rick Barber (SAIF), Defense Attorney

WCB 87-10673
June 2, 1988
Order of Abatement

Claimant, pro se, has asked that the Board reconsider its May 10, 1988 Order on Review. Pursuant to our order, we affirmed a Referee's order that: (1) declined to grant permanent total disability; and (2) increased claimant's unscheduled permanent disability award for a low back condition from 30 percent (96 degrees), as granted by a Determination Order, to 50 percent (160 degrees). Enclosing additional documents in support of her request, claimant reiterates her contention that he is permanently and totally disabled.

In order to allow sufficient time to consider claimant's request, the Board's May 10, 1988 order is abated and withdrawn. The SAIF Corporation is asked to file its response to claimant's request within 14 days from the date of this order. Thereafter, we shall take this matter under advisement.

IT IS SO ORDERED.

BILLIE I. RUMPEL, Claimant
Yturri, Rose, et al., Claimant's Attorneys
Rick Barber (SAIF), Defense Attorney

WCB 85-01331
April 15, 1988
Order of Abatement

On March 24, 1988, we issued an Interim Order of Remand, referring this matter to the Referee with instructions to reconvene a hearing. Our action was prompted by the hearing reporter's failure to provide a transcript of the parties' previous hearing.

Since the issuance of our order, the Board has received a partial hearing transcript concerning another longstanding case involving this same hearing reporter. In addition, the reporter has assured the Board that the transcript in this case will soon be forthcoming.

The Board's receipt of the entire transcript of the prior hearing will obviate the need for a new hearing. Considering the aforementioned recent events, we conclude that a new hearing may not be required. Therefore, the hearing date, currently scheduled for June 29, 1988, is cancelled.

Accordingly, our March 24, 1988 Interim Order of Remand is abated and withdrawn. We shall continue to closely monitor this matter and keep the parties fully advised of further developments in this case.

IT IS SO ORDERED.

WORKERS' COMPENSATION CASES

Decided in the Oregon Supreme Court:

	page
Dunn v. SAIF (6/1/88)	700
Georgia-Pacific Corp. v. Piwowar (4/19/88)	674
Greenslitt v. City of Lake Oswego (4/26/88)	683
Guill v. Pendleton Woolen Mills (4/26/88)	688
Nicholson v. Blachly (5/3/88)	693
North Clackamas School District v. White (4/19/88)	672
Seibel v. Liberty Homes, Inc. (3/29/88)	662
Short v. SAIF (4/26/88)	689
Stovall v. Sally Salmon Seafood (6/7/88)	701
Weyerhaeuser Co. v. Miller (6/1/88)	696

Decided in the Oregon Court of Appeals:

Adams v. Edwards Heavy Equipment, Inc. (4/6/88)	624
Armstrong v. Asten-Hill Co. (3/23/88)	616
Berliner v. Weyerhaeuser Co. (4/20/88)	629
Chapel of Memories v. Davis (5/18/88)	649
DeSylvia v. Multnomah County School District #40 (6/1/88)	660
EBI Co. v. Grover (4/20/88)	631
Edward Hines Lumber Co. v. Kephart (4/20/88)	633
George v. Richard's Food Center (4/20/88)	635
Gwynn v. SAIF (5/11/88)	638
Hunter v. Teledyne Wah Chang (6/1/88)	659
International Paper Co. v. Turner (5/11/88)	642
Janzen v. Sunriver Lands, Inc. (12/23/87)	614
Krajacic v. Blazing Orchards (4/20/88)	632
Mathis v. Modoc Lumber Co. (5/11/88)	636
McGill v. SAIF (5/18/88)	647
Moore v. Kaiser Permanente (5/18/88)	653
Neihart v. Roseburg Lumber Co. (4/13/88)	628
Newkirk v. Curry Good Samaritan Center (3/23/88)	620
Palmer v. Central Oregon Irrigation District (5/11/88)	644
Scarino v. SAIF (6/1/88)	655
Western Employers Ins. v. Foster (4/6/88)	622

IN THE COURT OF APPEALS OF THE STATE OF OREGON

JANZEN,
Appellant,
v.
SUNRIVER LANDS, INC.,
Respondent.
(36791; CA A38634)

On remand from the Oregon Supreme Court, *Janzen v. Sunriver Lands, Inc.*, 304 Or 278, 743 P2d 1115 (1987).

Appeal from Circuit Court, Deschutes County.

Walter I. Edmonds, Jr., Judge.

Submitted on remand November 23, 1987.

Mike Stebbins and Hayner, Stebbins & Coffey, North Bend, for appellant.

William M. Holmes and Gray, Fancher, Holmes, Hurley & Bischof, Bend, for respondent.

Susan P. Graber, Eileen Drake and Stoel, Rives, Boley, Fraser & Wyse, Portland, filed a brief *amici curiae* for A-Dec, Inc.; Bohemia, Inc.; Good Samaritan Hospital; Kaiser Foundation Health Plan of the Northwest and Kaiser Foundation Hospitals; Les Schwab Tire Centers of Oregon and Les Schwab Warehouse Center, Inc.; Leupold & Stevens, Inc.; and Precision Castparts Corp.

Before Richardson, Presiding Judge, and Newman and Deits, Judges.

RICHARDSON, P. J.

Reversed and remanded on Count I for further proceedings not inconsistent with this opinion; otherwise affirmed.

RICHARDSON, P. J.

The Supreme Court remanded this case to us for reconsideration in the light of its decision in *Knapp v. City of North Bend*, 304 Or 34, 741 P2d 505 (1987). 304 Or 278, 743 P2d 1115 (1987). Plaintiff, a former employe of defendant, was not reinstated to his former position as a cook when he was released to return to work after suffering a compensable injury. Defendant also declined to employ plaintiff in its public safety department, and he contends that it thereby failed to place him in another "available and suitable" position.

In our earlier consideration of the appeal, we reversed and remanded the trial court's summary judgment for defendant. We concluded that ORS 659.415(1)[1] requires an

[1] ORS 659.415(1) provides:

"A worker who has sustained a compensable injury shall be reinstated by the worker's employer to the worker's former position of employment upon demand for such reinstatement, provided that the position is available and the worker is not disabled from performing the duties of such position. If the former position is not available, the worker shall be reinstated in any other position which is available and suitable. A certificate by a duly licensed physician that the physician approves the worker's return to the worker's regular employment shall be prima facie evidence that the worker is able to perform such duties."

employer, when an employe returns to work after a compensable injury, to reinstate the employe to his former position, notwithstanding that the position has been filled during the employe's absence. *Janzen v. Sunriver Lands, Inc.*, 83 Or App 510, 732 P2d 35, *on reconsideration* 85 Or App 38, 735 P2d 376 (1987). The Supreme Court interpreted the statute in the opposite manner in *Knapp v. City of North Bend, supra.* Consequently, we reject plaintiff's first assignment of error, relating to defendant's failure to reinstate him to his former position.

In his second assignment, plaintiff contends that the trial court erred by granting summary judgment against him on his claim that defendant violated ORS 659.415(1) by not placing him in the public safety position. We agree. An employer's failure to place an employe in "any other position which is available and suitable," if the employe's former position is not available and if he is not disabled from performing the alternative job, is a violation of ORS 659.415. Defendant presented evidence that its personnel director believed that plaintiff could not perform as a public safety officer because of

his physical problems. However, there was also some evidence that that belief was contrary to medical opinion. There is an issue of material fact. Defendant's contrary argument and its other arguments for rejecting plaintiff's second assignment are unpersuasive, and we hold that the court erred by granting summary judgment on the issue.

It follows from our disposition of plaintiff's second assignment that we also agree with his third, in which he argues, *inter alia*, that it was error to grant summary judgment on his contention that his discharge and the failure to place him in an available and suitable position violated ORS 659.410.

We rejected defendant's fourth assignment in our earlier opinion on reconsideration, and we do not understand that assignment to come within the Supreme Court's remand.

Reversed and remanded on Count I for further proceedings not inconsistent with this opinion;[2] otherwise affirmed.

[2] The first three assignments all pertain to Count I of the complaint.

IN THE COURT OF APPEALS OF THE
STATE OF OREGON

In the Matter of the Compensation of
Robert D. Armstrong, Claimant.

ARMSTRONG,
Petitioner,

v.

ASTEN-HILL COMPANY et al,
Respondents.

(WCB No. 86-02776; CA A45124)

Judicial Review from Workers' Compensation Board.

Argued and submitted February 12, 1988.

Brian R. Whitehead, Salem, argued the cause and filed the brief for petitioner.

Paul L. Roess, Portland, argued the cause for respondents. With him on the brief was Acker, Underwood & Smith, Portland.

Before Warden, Presiding Judge, and Joseph, Chief Judge, and Van Hoomissen, Judge.

JOSEPH, C. J.
Remanded for reconsideration.

JOSEPH, C. J.

The petition for judicial review in this workers' compensation case was filed on July 27, 1987. HB 2900 was approved by the Governor on July 20, 1987, and filed in the office of the Secretary of State on July 21, 1987. It became Oregon Laws 1987, chapter 884. Section 12a amended ORS 656.298(6) by eliminating the language imposing on this court an obligation to conduct *de novo* review in workers' compensation cases and by providing, instead: "Review shall be as provided in ORS 183.482(7) and (8)."[1] Section 12b provides: "The

[1] The sections of the Administrative Procedures Act to which the 1987 amendment refers provide:

"(7) Review of a contested case shall be confined to the record, the court shall not substitute its judgment for that of the agency as to any issue of fact or agency discretion. In the case of disputed allegations of irregularities in procedure before the agency not shown in the record which, if proved, would warrant reversal or remand, the Court of Appeals may refer the allegations to a Master appointed by the court to take evidence and make findings of fact upon them. The court shall remand the order for further agency action if it finds that either the fairness of the proceedings or the correctness of the action may have been impaired by a material error in procedure or a failure to follow prescribed procedure.

"(8)(a) The court may affirm, reverse or remand the order. If the court finds that the agency has erroneously interpreted a provision of law and that a correct interpretation compels a particular action, it shall:

"(A) Set aside or modify the order; or

"(B) Remand the case to the agency for further action under a correct interpretation of the provision of law.

"(b) The court shall remand the order to the agency if it finds the agency's exercise of discretion to be:

"(A) Outside the range of discretion delegated to the agency by law;

"(B) Inconsistent with an agency rule, an officially stated agency position, or a prior agency practice, if the inconsistency is not explained by the agency; or

"(C) Otherwise in violation of a constitutional or statutory provision.

"(c) The court shall set aside or remand the order if it finds that the order is not supported by substantial evidence in the record. Substantial evidence exists to support a finding of fact when the record, viewed as a whole, would permit a reasonable person to make that finding."

amendments * * * by section 12a * * * do not apply to appeals [*sic*] of which the Court of Appeals acquired jurisdiction before the effective date of this Act." Section 63(1) provides: "Sections 1, 3 to 40 and 42 to 46 of this Act first become operative January 1, 1988." Section 64 provides: "This Act being necessary for the immediate preservation of the public peace, health and safety, an emergency is declared to exist, and this Act takes effect on its passage."[2]

The language of section 64 is commonly known as an "emergency clause." Article IV, section 28, of the Oregon Constitution provides: "No act shall take effect, until ninety days from the end of the session at which the same shall have been passed, except in case of emergency; which emergency shall be declared in the preamble, or in the body of the law." The "effective date" of an act containing a declaration of an emergency is the date when it is signed by the Governor. *Bennett Trust Co. v. Sengstacken,* 58 Or 333, 343-344, 113 P 863 (1911); *see also State ex rel. Thomas v. Hoss,* 143 Or 41, 47, 21 P2d 234 (1933). Therefore, the effective date of the act was July 20, 1987. This court acquired jurisdiction by the filing of the petition for judicial review after that date. ORS 656.298(3); ORS 19.033(1). Therefore, the exception in section 12b is inapplicable in this case.

By legislative direction the provision changing the scope of review "first bec[a]me operative January 1, 1988." We need not discuss what might have been the scope of review of a petition for judicial review filed after July 20 and submitted for decision by this court before January 1, 1988. No such case happened. Although petitioner argues strenuously in his memorandum that the statute is ambiguous when applied to this case, that is just not so. The language of the statute unambiguously expresses the intent of the legislature that this court exercise only the scope of review described in section 12a of the 1987 Act after January 1, 1988, in a case as to which it obtained jurisdiction after July 20, 1987. There is, therefore, no need to resort to canons of statutory construction or to legislative history (none of which has been cited to us or found) to determine the intent of the legislature. *Whipple v. Howser,* 291 Or 475, 632 P2d 782 (1981). Because "[t]he words used speak for themselves," *Berry Transport, Inc. v. Heltzel,* 202 Or 161, 167, 272 P2d 965 (1954), we need only look to the plain meaning of the statute to determine whether the substantial evidence review standard applies. It applies in this case.

Petitioner also argues that the former *de novo* review

is a substantive right which is subject to ORS 656.202(2), which provides:

---

[2] Because this is the first workers' compensation case in which the petition for judicial review was filed after July 20, 1987, we requested the parties to submit memoranda concerning the scope of review. Those memoranda were carefully and conscientiously prepared and have been of substantial assistance.

"Except as otherwise provided by law, payment of benefits for injuries or deaths under ORS 656.001 to 656.794 shall be continued as authorized, and in the amounts provided for, by the law in force at the time the injury giving rise to the right to compensation occurred."[3]

That statute applies only to substantive rights to compensation, not to the procedure for applying those rights. *Johnson v. SAIF*, 78 Or App 143, 714 P2d 1098, *rev den* 301 Or 240 (1986). The scope of review has nothing to do with entitlement to "payment of benefits * * * as authorized, and in the amounts provided for, by the law in force at the time [of] the injury * * *."

Implicit in petitioner's argument is that this problem must be analyzed as involving retrospective application of a new statute that affects legal rights and obligations arising out of past actions. *See Joseph v. Lowery*, 261 Or 545, 495 P2d 273 (1972); *Wick v. SAIF*, 37 Or App 285, 587 P2d 477 (1978). The adjudication of rights and liabilities is, in the absence of an express contrary legislative direction, to be accomplished under the statutes in effect at the time of the adjudication. *Holmes v. SAIF*, 38 Or App 145, 589 P2d 1151 (1979).

In *Wick v. SAIF, supra*, we noted that a 1977 amendment to the Workers' Compensation Law shifting review from the circuit court to the Court of Appeals did not change the rights and obligations of the parties. 37 Or App at 290 n 5. We contrasted that procedural change with another change in 1977 making the disputable fireman's presumption of work-relatedness conclusive. We said that the latter change would impose liability where it had not existed previously because of the greater evidentiary burden placed on employers. The change from *de novo* review to substantial evidence review places no greater evidentiary burden on claimants or on

employers. The change in the scope of review does not affect any party's substantive rights.

We hold that the scope of review in this and all workers' compensation cases in which petitions for review are filed in the Court of Appeals after July 20, 1987, is that described in section 12a.

Neither ORS 183.482(7) nor ORS 183.482(8) describes what a final order in a contested case must contain. ORS 183.470(2) provides:

"A final order shall be accompanied by findings of fact and conclusions of law. The findings of fact shall consist of a concise statement of the underlying facts supporting the findings as to each contested issue of fact and as to each ultimate fact required to support the agency's order."

Although the 1987 amendments to the Workers' Compensation Law do not specifically refer to that statute, we hold that

[3] Section 62(1) of the 1987 Act provides, in part:

"Notwithstanding ORS 656.202, amendments by this Act to * * * ORS 656.298 * * * become operative January 1, 1988."

The apparent purpose of that provision is to avoid the possible application of ORS 656.202 to cases subject to the 1987 Act's amendments.

it applies in substance to Board orders, because it states requirements which are necessary for effective judicial review.

ORS 183.482(8)(c) requires us to set aside or remand a final order which is not supported by substantial evidence in the record. In order for us to conduct that kind of review, we must be able to know what the Board found as fact and why it believes that its findings led to the conclusions that it reached.[4] That requires a reasoned opinion based on explicit findings of fact. As we said in *Home Plate, Inc. v. OLCC,* 20 Or App 188, 190, 530 P2d 862 (1975):

> "If there is to be any meaningful judicial scrutiny of the activities of an administrative agency—not for the purpose of substituting judicial judgment for administrative judgment but for the purpose of requiring the administrative agency to demonstrate that it has applied the criteria prescribed by statute and by its own regulations and has not acted arbitrarily or on an *ad hoc* basis—we must require that its orders clearly and precisely state what it found to be the facts

> and fully explain why those facts lead it to the decision [which] it makes."

Thus, substantial evidence review necessarily requires findings like those that ORS 183.470(2) explicitly requires. The requirement of findings leads to a requirement that the agency state its reasoning. *See Springfield Education Assn. v. School Dist.,* 290 Or 217, 227, 621 P2d 547 (1980).[5]

ORS 183.482(8)(c) states: "Substantial evidence exists to support a finding of fact when the record, viewed as a whole, would permit a reasonable person to make that finding." We have never decided the meaning of that language. However, in *Brown v. AFSD,* 75 Or App 98, 705 P2d 236 (1985), *rev den* 300 Or 477 (1986), where the issue was whether the "any evidence rule" applied under an earlier version of ORS 183.482(8)(c), which did not contain that definition, *dicta* in all of the opinions recognized that the statute as now written incorporates what has been referred to as the "federal" substantial evidence test. That test, enunciated in *Universal Camera Corp. v. NLRB,* 340 US 474, 487, 71 S Ct 456, 95 L Ed 456 (1951), requires us to look at the whole record with respect to the issue being decided, rather than at one piece of evidence in isolation. If an agency's finding is reasonable, keeping in mind the evidence against the finding as well as the evidence supporting it, there is substantial evidence. That is not what has been referred to as the "any evidence" rule, *see* 75 Or App at 105 (Warren, J., concurring), but it is also *not de novo* review. For instance, and in a context which is likely frequently to occur in workers' compensation cases, if there are doctors on both sides of a medical issue, whichever way the Board finds the facts will probably have substantial evidentiary support. We would not need to choose sides. The difference between the "any evidence" rule and the substan-

[4] Nothing in this opinion should be taken as determining that the Board must, in every instance, write its own findings of fact and conclusions in its order on *de novo* review of the decision of a referee. ORS 656.295(6). It may adopt the opinion and order of a referee in whole or in part; it may write its own order in whole or in part. Its obligation is to provide for our review a final order satisfying the import of ORS 183.470(2).

[5] We note that the Workers' Compensation Law already requires that Board orders meet procedural requirements similar to those stated in the APA. ORS 656.289; ORS 656.295.

tial evidence test in ORS 183.482(8)(c) will be decisive only when the credible evidence apparently weighs overwhelmingly in favor of one finding and the Board finds the other without giving a persuasive explanation.

We turn now to the Board order in this case. Claimant, a former worker in a textile factory, filed an occupational

disease claim, asserting that dusty conditions in the mill constitute the major contributing cause of his chronic rhinitis. Employer denied the claim. The referee set aside the denial.[6] On *de novo* review the Board reversed by a detailed opinion, culminating in a conclusion that the disease is not compensable.

The order does not satisfy the standards we have described. It is for the most part merely a recitation of evidence, followed by a bare conclusion. It lacks an ordered set of findings of fact and is devoid of any explanation of why facts supported by evidence lead to its conclusion. Therefore, it is inadequate for judicial review.

Remanded for reconsideration.

[6] Although the referee's opinion and order is not subject to our review, we note that she attempted to identify and state separately the issue, her findings of fact and her conclusions and the reasons therefor.

IN THE COURT OF APPEALS OF THE STATE OF OREGON

In the Matter of the Compensation of Beverly Newkirk, Claimant.

NEWKIRK,
Petitioner,

v.

CURRY GOOD SAMARITAN CENTER,
Respondent.

(85-11733; CA A42695)

Judicial Review from Workers' Compensation Board.

Argued and submitted November 25, 1987.

Robert F. Webber, Medford, argued the cause and filed the brief for petitioner.

Deborah L. Sather, Portland, argued the cause for respondent. With her on the brief was Moscato & Byerly, Portland.

Before Warden, Presiding Judge, and Joseph, Chief Judge,* and Van Hoomissen, Judge.

WARDEN, P. J.

Reversed and remanded for recalculation of benefits consistently with this opinion.

* Joseph, C. J., *vice* Young, J., deceased.

WARDEN, P. J.

Claimant seeks review of a Workers' Compensation Board order that found that her temporary total disability (TTD) benefits had been properly calculated. We reverse and remand.

Claimant was hired by Curry Good Samaritan Center (Curry) as a part-time nursing assistant. Her working hours were to vary, depending on her availability and Curry's needs. She began work on June 12, 1983, and worked 45 hours that week, including 37 hours of job orientation. She was injured at work during that first week, on June 17, but did not report the injury to Curry until July 20. In the four weeks following her injury she worked 37, 29 1/4, 32 and 25 hours, respectively. She worked only 16 hours in three days in the last week before she stopped working because of the June 17 injury.

ORS 656.210(2)(b)(B) provides that TTD benefits "shall be based on the wage of the worker at the time of injury." *Former* OAR 436-54-212 *(now* OAR 436-60-020) provides, in pertinent part:

> "(4) The rate of [TTD] compensation for workers employed with unscheduled, irregular or no earnings shall be computed on the wages determined in the following manner:
>
> "(a) Employed on call basis: Use average weekly earnings for past 26 weeks, if available, unless periods of extended gaps exist, then use no less than last 4 weeks of employment to arrive at average. For workers employed less than 4 weeks, or where extended gaps exist within the 4 weeks, use intent at time of hire as confirmed by employer and worker.
>
> "* * * * *
>
> "(c) Employed varying hours, shifts or wages: Use average as in subsection (a)."

Under that rule, claimant's TTD benefits are to be based on her weekly earnings for the five full weeks of her employment, before the week when she stopped working, because she was not employed less than four weeks and there were no extended gaps in her employment.

It is undisputed that claimant was hired as a "part-time" employe, with her hours to vary according to her availability and Curry's needs. On that basis, claimant's TTD benefits should be calculated on the basis of her weekly average of

33.65 hours. We include the hours devoted to job orientation as hours worked during claimant's first week in our calculation, because she was required to be at the workplace for those hours, just as she was later in performing services for Curry.

Reversed and remanded for recalculation of benefits consistently with this opinion.

IN THE COURT OF APPEALS OF THE
STATE OF OREGON

In the Matter of the Compensation
of Jerry F. Foster, Claimant.
WESTERN EMPLOYERS INSURANCE et al,
Petitioners,
v.
FOSTER et al,
Respondents.
(WCB 84-11283; WCB 84-12837; CA A43398)

Judicial Review from Workers' Compensation Board.

Argued and submitted November 13, 1987.

Jerry K. Brown, McMinnville, argued the cause for petitioners. On the brief were Karen V. Wiggins and Cummins, Cummins, Brown, Goodman & Fish, P.C., McMinnville.

James L. Edmunson, Eugene, argued the cause for respondent Jerry F. Foster. On the brief were Karen M. Werner and Malagon & Moore, Eugene.

David Horne, Beaverton, argued the cause for respondents Roseburg Lumber Company and Wausau Insurance Company. On the brief was Constance L. Wold, Beaverton.

Before Buttler, Presiding Judge, and Warren and Rossman, Judges.

WARREN, J.

Affirmed.

WARREN, J.

Claimant experienced an incident involving his back while working at Quiet Valley Veneer (Quiet Valley) in 1983. He filed a claim with Western, Quiet Valley's insurer, seeking benefits for an injury, and also filed an aggravation claim with Wausau, insurer for his previous employer, alleging that the incident was an aggravation of a compensable 1973 injury. Both insurers denied the claim, but Wausau voluntarily began paying benefits for temporary total disability and also paid for vocational assistance.

The referee and the Board held that claimant had a new injury and that Western was responsible for payment of benefits. On *de novo* review, we affirm that determination. We write only to address Western's contention that the referee erred in requiring that it reimburse Wausau for amounts that Wausau had paid for vocational assistance and temporary total disability after claimant allegedly became medically stationary.

More than five years had passed from the date of claimant's injury at Wausau's insured to the date of the incident at Quiet Valley. For that reason, claimant's aggravation claim against Wausau was considered by the Board on its own

motion. Although neither insurer has seriously contested the compensability of the back condition, because the aggravation claim fell within the Board's own motion jurisdiction, neither insurer applied for, and the Board never entered, an order under ORS 656.307 designating a paying agent.[1] Wausau therefore paid temporary total disability and vocational assistance benefits at a time when claimant was not entitled to them.[2]

When the claim was determined to be the responsibility of Western as a new injury, however, claimant had not yet been released for work and Western had the obligation to pay temporary total disability benefits from the time of the

injury until claimant was determined by the Evaluation Division to be medically stationary. ORS 656.268; *Vip's Restaurant v. Krause*, 89 Or App 214, 748 P2d 164 (1988). The referee therefore properly required Western to reimburse Wausau for time loss benefits that it had paid up to the time of the determination order, despite the fact that there is evidence that claimant became medically stationary before that date.

The analysis is different with respect to the vocational assistance, but the result is the same. Although Western had no obligation to provide vocational assistance during the time when Wausau was providing it, it did have an obligation to provide it after it became responsible for the claim. *See* ORS 656.340. Western does not contend that the services were untimely or inappropriate in the light of claimant's condition. Western also does not contend that the vocational assistance did not work to satisfy its obligation to claimant. We conclude that Western's obligation to pay for vocational assistance includes the duty to reimburse Wausau for appropriate services provided to the extent that those services satisfied Western's obligation. The Board properly ordered reimbursement for vocational assistance.

Affirmed.

---

[1] OAR 436-60-180(3) provides that cases under the Board's own motion jurisdiction are exempt from the procedures for designating a paying agent.

[2] Western does not claim that, because Wausau was a "volunteer," Western had *no* obligation to reimburse it.

IN THE COURT OF APPEALS OF THE
STATE OF OREGON

In the Matter of the Compensation of
JAMES W. ADAMS, Claimant.

ADAMS,
Respondent - Cross-Petitioner,

v.

EDWARDS HEAVY EQUIPMENT, INC., et al,
Petitioners - Cross-Respondents.

(WCB No. 84-10811; CA A41735)

Judicial Review from Workers' Compensation Board.

Argued and submitted August 31, 1987.

David O. Horne, Beaverton, argued the cause and filed the briefs for petitioners - cross-respondents.

Robert Wollheim, Portland, argued the cause for respondent - cross-petitioner. With him on the brief was Welch, Bruun & Greene, Portland.

Before Richardson, Presiding Judge, and Newman and Deits, Judges.

NEWMAN, J.

On petition, affirmed; on cross-petition, modified to provide that permament total disability payments begin on July 15, 1985; otherwise affirmed.

NEWMAN, J.

In this aggravation claim, employer petitions for review of an order of the Workers' Compensation Board that affirmed the referee's award of permanent total disability. Claimant cross-petitions for review of the Board's determination that January 24, 1986, is the date on which permanent total disability payments should begin. On the petition, we affirm; on the cross-petition, we reverse.

Claimant was a heavy machine operator. He injured his lower back and right knee at work in April, 1980. His claim was closed in October, 1980, and he received an award of scheduled and unscheduled permanent partial disability. Between 1980 and April, 1984, he continued to have difficulty with his right knee. He had repeated surgery. Twice he received an additional award for permanent partial disability. The last award was on April 24, 1984, by a stipulated order. Physically unable to return to his previous occupation after his intital injury, he participated in a retraining program to learn small engine repair. He had a heart attack in July, 1982, and by-pass surgery in August, 1982. He made a good recovery and then held short term jobs until he was forced to stop because of his knee and a shortage of jobs due to economic conditions.

On July 12, 1984, claimant underwent exploratory surgery for increasing knee pain. His claim was reopened for

medical expenses. In August, Dr. Keist, the treating orthopedic surgeon, stated that he believed that claimant would

> "return to pre-operative status and can be removed from time loss as of September 15, 1984. There should be no change in his permanent impairment award at that time."

In October, 1984, claimant requested a hearing and asked for temporary total disability and a redetermination of permanent partial disability. On December 6, 1984, Keist stated that claimant's condition was medically stationary. On February 11, 1985, claimant's case was again closed by a determination order which awarded temporary total disability, less time worked, from July 12, 1984, through December 6, 1984, but no increase in permanent partial disability.

On February 13, 1985, claimant filed a supplemental

request for a hearing and asked for permanent total disability. In May, 1985, he complained to Keist of severe right knee pain. Keist prescribed physical therapy and attributed the increased pain to irritation of the synovium and scarring. He rated claimant's overall impairment as severe and limited him to walking no more than one hour per day, sitting two hours per day and standing two hours a day. He indicated that claimant could occasionally lift 50 pounds. Subsequently, he authorized time loss from May 22, 1985, to July 15, 1985.

In September, 1985, claimant filed another request for hearing, seeking additional time loss, as well as permanent total disability. On January 13, 1986, Keist wrote:

> "This man has multiple orthopedic problems, primarily at this time centered on his right knee. He has had total knee arthroplasty with one replacement. He has continuing complaints of pain and inability to function in his knee. He has objective demonstration of limitation of motion and weakness of his right knee that would make working at anything but the most sedentary work impossible.
>
> "It is possible that this man can occasionally lift 10 pounds, although he had had previous low back difficulty.
>
> "His objective evidence of orthopedic impairment would be in the moderately severe category.
>
> "This man has cardiac problems, psychologic problems and multiple orthopedic problems. His condition is stationary and slowly deteriorating. Treatment would not be beneficial. The overall combination of impairments make this man a total and permanent disability case in my opinion."

At the hearing on January 24, 1986, claimant testified that his condition had worsened after April 24, 1984. He testified that, before that time, he had walked one or two miles daily but now could only walk one-half mile and, even then, only with pain. His testimony was corroborated by Keist's chart notes. Claimant also described his increasingly disabling back pain. He testified that he avoids lifting grocery bags and any twisting, driving or walking down stairs and that, if he sits more than one hour, his leg gets numb. He lies down at least one hour daily to relieve pain and, due to his physical condition, he had had difficulty doing small engine repair work. His last job was in December, 1982. He continued to seek work in 1983, but sometime in 1984 had stopped looking because of his

increased knee and back pain and because, when he told employers of his physical limitations, they would not hire him.

Claimant's vocational expert testified that claimant could no longer perform bench work, given his orthopedic restrictions, and that he would require additional training to do small electrical appliance repair work. That testimony is consistent with the medical evidence. Employer's vocational expert testified that claimant might be able to do small engine or small appliance repair work, but her assumptions about claimant's physical limitations were contrary to the medical evidence.

The referee concluded that claimant was permanently and totally disabled. He first found:

> "He is certainly precluded from performing any of his previous occupations. However, without inclusion of his heart condition, no doctor has expressed an opinion that claimant is permanently and totally disabled. It is a close question but based on the evidence I find that claimant is not totally incapacitated by his pre-injury conditions and the residuals of his industrial injury."

After considering non-medical factors, however, he found that claimant had proven permanent total disability:

> "Considering claimant's age of 65, his receipt of social security benefits for some time, not having worked for over three years and with his physical restrictions on lifting, bending, walking, standing and sitting because of his right knee and low back condition, I find claimant is permanently and totally disabled from working at a gainful and suitable occupation."

He also found that claimant had demonstrated his willingness to re-enter the work force. After his initial injury, he had participated in retraining. He had worked until his heart attack and by-pass surgery and, after recovery, had returned to work until the economy and his physical condition worsened. The referee concluded that it would have been futile for claimant to continue to seek employment. The Board affirmed.

Employer argues that the Board erred in determining that claimant was totally and permanently disabled, because

his condition had not worsened after April, 1984,[1] and he had not proved that he had sought work since that time. ORS 656.206(3).

To be entitled to an award of permanent total disability, a claimant must show that, since the last arrangement of compensation, the condition which gave rise to the original award has permanently worsened, *Stepp v. SAIF*, 304 Or 375, 381, 745 P2d 1207 (1987), and that, because of the worsened condition, he has suffered a total loss of earning capacity.

[1] A claimant has to prove a worsening of his condition after the last "award or arrangement of compensation." ORS 656.273(1). Claimant here contested the February 11, 1985, determination order, so the April 24, 1984, stipulated order is the last arrangement of compensation.

Smith v. SAIF, 302 Or 396, 401, 730 P2d 30 (1986). If he seeks permanent total disability under the "odd lot" doctrine, he must demonstrate that he is willing to re-enter the work force and that he has made reasonable efforts to do so, unless that would be futile. *Butcher v. SAIF*, 45 Or App 313 (1980).

We conclude that claimant's right knee and back have worsened since the April, 1984, stipulated order. Employer presented no medical evidence that claimant's condition was unchanged, nor did it challenge claimant's credibility. Moreover, the referee implicitly found claimant credible. *See Locke v. SAIF*, 21 Or App 725, 726, 536 P2d 534 (1975). We agree with the Board that claimant was totally and permanently disabled for the reasons stated in the referee's opinion and order. Given his physical restrictions, skills and age, it would have been futile for claimant to attempt to find a job.

On claimant's cross-petition, he asserts that the Board erred when it determined that his permanent and total disability payments should begin on January 24, 1986, the date of the hearing, rather than on December 6, 1984, when Keist found him to be medically stationary. The effective date of a modification of a permanent disability award is the earliest date when a claimant proves that all elements necessary to his claim existed. *Morris v. Denny's*, 50 Or App 533, 623 P2d 1118, *mod* 53 Or App 863, 867, 633 P2d 827 (1981). Claimant, therefore, is entitled to permanent disability benefits from the earliest date that he can prove that (1) his condition had

worsened since the last arrangement of compensation in April, 1984, and (2) he was permanently and totally disabled.

Keist had rated claimant's impairment in April, 1984, as moderate. On December 6, 1984, he found claimant's condition to be medically stationary, but his notes reveal that he then believed claimant's permanent impairment had not changed after April, 1984. On May 17, 1985, however, Keist found that claimant's knee had "given out on him" numerous times and that he had increased pain and decreased mobility. Keist then rated claimant's impairment as severe. His condition had worsened after April, 1984. In his January 13, 1986, opinion letter, Keist stated for the first time that claimant was totally and permanently disabled. The record shows, however, that all medical factors that Keist relied upon in his letter had existed by July 15, 1985, when he terminated physical therapy and declined to operate, believing that further treatment would not be beneficial. In addition, all vocational and social factors relevant to claimant's permanent total disability existed then. Accordingly, we conclude that claimant's permanent total disability payments should begin as of July 15, 1985.

On petition, affirmed; on cross-petition, modified to provide that permanent total disability payments begin on July 15, 1985; otherwise affirmed.

IN THE COURT OF APPEALS OF THE
STATE OF OREGON

In the Matter of the Compensation of
Ward Neihart, Claimant.

NEIHART,
Petitioner,

v.

ROSEBURG LUMBER COMPANY et al,
Respondents.

(WCB 85-13216; CA A42468)

Judicial Review from Workers' Compensation Board.

Argued and submitted January 20, 1988.

James L. Edmunson, Eugene, argued the cause for petitioner. With him on the brief were Karen M. Werner and Malagon & Moore, Eugene.

H. Scott Plouse, Medford, argued the cause and filed the brief for respondents.

Before Warden, Presiding Judge, and Joseph, Chief Judge, and Van Hoomissen, Judge.

PER CURIAM

Reversed and remanded to referee for consideration of new evidence.

PER CURIAM

Claimant seeks review of a Workers' Compensation Board order that reversed the referee and reinstated the insurer's denial of compensability of certain proposed surgical procedures. After the Board issued its order, the surgical procedures were performed. We allowed the record to be supplemented by new evidence relating to the surgeries and claimant's post-operative condition. Because the new evidence could affect the issue of whether the surgical procedures are compensable under ORS 656.245, we reverse and remand to the referee for consideration of the new evidence. *Cain v. Woolley Enterprises,* 83 Or App 213, 730 P2d 1274 (1986).

Reversed and remanded to the referee for consideration of new evidence.

IN THE COURT OF APPEALS OF THE
STATE OF OREGON

In the Matter of the Compensation of
Dennis Berliner, Claimant.

BERLINER,
Petitioner,

v.

WEYERHAEUSER COMPANY,
Respondent.

(WCB 85-12191; CA A43382)

Judicial review from Workers' Compensation Board.

Argued and submitted November 6, 1987.

James L. Edmunson, Eugene, argued the cause for petitioner. With him on the brief were Karen M. Werner and Malagon & Moore, Eugene.

Paul Roess, Coos Bay, argued the cause for respondent. With him on the brief was Foss, Whitty & Roess, Coos Bay.

Before Warden, Presiding Judge, and Joseph, Chief Judge,* and Van Hoomissen, Judge.

JOSEPH, C. J.

Remanded for further evidence taking in accordance with this opinion.

* Joseph, C. J., *vice* Young, J., deceased.

JOSEPH, C. J.

Claimant seeks review of a "republished" order of the Workers' Compensation Board. Because we cannot determine whether it acted properly in republishing its order, we remand to the referee for further evidence taking.

The Board initially published its order on October 8, 1986. Claimant never sought review of that order. In January, 1987, claimant and his attorney submitted affidavits to the Board which stated that neither of them had ever received the October 8, 1986, order. On February 19, 1987, the Board republished its order. The republished order is exactly the same as the first order except for its date and the first paragraph:

> "Based on the affidavits submitted, the record herein, and in the interests of substantial justice, we are persuaded that our October 8, 1986 order in this matter was not mailed to claimant's attorney. Consequently, that order has not become final. ORS 656.295(8); *Armstrong v. SAIF,* 67 Or App 498 (1984). Since our prior order has not become final, we have jurisdiction to republish it, which we hereby do as follows."

On *de novo* review, however, we cannot determine whether the October, 1986, order was mailed to the parties, or

why the Board concluded that it was not. Claimant's and his attorney's affidavits can establish only that the order was never received, not that it was not mailed. The rest of the record reveals only a standard paragraph at the end of the original order that copies were mailed to all the proper parties on a particular date. That paragraph contradicts the Board's subsequent conclusion that it did not mail the order. On that record, we cannot determine whether the Board mailed its first order.

If the Board mailed that order, it became final 30 days later, and the Board lacked jurisdiction to "republish it." If the order was not mailed to all parties, then the order was not final, and the Board could republish it. Claimant timely petitioned for review of the republished order.

This court has authority to remand, ORS 656.298(6)

(1985),[1] for taking evidence about whether the Board mailed its October 8 order to the parties. We direct that the referee report that evidence to us directly within 60 days of the effective date of this decision. We will then, on *de novo* review, determine the facts. We retain jurisdiction over the petition pending the referee's report. *Armstrong v. SAIF,* 58 Or App 602, 649 P2d 818, *rev den* 293 Or 801 (1982) (petition for review dismissed); 65 Or App 809, 811, 672 P2d 397 (1983) (remanded for evidence taking); 67 Or App 498, 500, 678 P2d 777 (1984).

Remanded for evidence taking in accordance with this opinion.

[1] ORS 656.298(6) was amended by Or Laws 1987, ch 884 § 12a. That amendment is not applicable here. *See* Or Laws 1987, ch 884, § 12b. *See Armstrong v. Aston-Hill,* 90 Or App 200, ____ P2d ____ (1988).

IN THE COURT OF APPEALS OF THE
STATE OF OREGON

In the Matter of the Compensation of
Barton M. Grover, Claimant.

EBI COMPANIES et al,
Petitioners,

v.

GROVER et al,
Respondents.

(WCB 85-14800; WCB 82-04073; CA A43932)

Judicial Review from Workers' Compensation Board.

Argued and submitted January 15, 1988.

Richard Wm. Davis, Portland, argued the cause for petitioners. With him on the brief was Davis, Bostwick, Scheminske & Lyons, Portland.

James L. Edmunson, Eugene, argued the cause for respondent Barton M. Grover. With him on the brief were Karen M. Werner and Malagon & Moore, Eugene.

Darrell E. Beweley, Salem, argued the cause for respondent SAIF Corporation. With him on the brief were Dave Frohnmayer, Attorney General, and Virginia L. Linder, Solicitor General, Salem.

Before Buttler, Presiding Judge, and Warren and Rossman, Judges.

WARREN, J.

Affirmed.

WARREN, J.

G & S Masonry and EBI Companies (EBI) seek review of a decision by the Workers' Compensation Board (Board) which awarded claimant permanent total disability and found EBI responsible.

Claimant was employed in a variety of capacities in the masonry business for approximately 39 years. At all times relevant to this proceeding he was self-employed. Workers' compensation insurance was provided first by EBI and then by SAIF. In January, 1979, claimant was diagnosed as having degenerative osteoarthritis in both knees. The condition was work related, and EBI accepted and paid the claim. He was awarded 10 percent scheduled permanent partial disability for each knee. His treating physician, Dr. Holbert, predicted that the condition would progressively get worse and eventually require surgery.

In December, 1980, claimant injured his back on the job while insured by SAIF. In 1982, he had back surgery and was awarded an additional 25 percent unscheduled permanent partial disability. He appealed the award, claiming that he was entitled to permanent total disability. In 1984, he was found to be suffering from a noncompensable shoulder condition.

Between 1982 and 1984, while the back appeal was pending, he had surgery on both knees. His 1979 knee claim was reopened for aggravation and closed by a determination order in November, 1985. His previous knee injury awards were increased to 40 percent scheduled permanent partial disability for his left knee and 45 percent for his right knee. He again appealed the determination order, contending that he was entitled to permanent total disability.

The two appeals were consolidated. The referee found claimant to be permanently and totally disabled and assigned full responsibility to SAIF. SAIF appealed. The Board affirmed the finding of permanent total disability but shifted responsibility to EBI. On *de novo* review, we affirm the finding of permanent total disability and turn to the issue of responsibility.

Claimant's injuries occurred over a number of years, and each materially contributed to his overall disability. The most recent injury that bears a causal relation to claimant's

total disability is the aggravation of the knee conditions. EBI was responsible for the first knee injury, and it was the aggravation of that injury that last contributed to the disability. *See Smith v. Ed's Pancake House,* 27 Or App 361, 556 P2d 258 (1976). EBI is the responsible carrier.

Affirmed.

IN THE COURT OF APPEALS OF THE STATE OF OREGON

In the Matter of the Compensation of Steve Krajacic, Claimant.

KRAJACIC,
Petitioner,

v.

BLAZING ORCHARDS et al,
Respondents.

(WCB 84-02476; CA A37693)

On remand from the Oregon Supreme Court, *Krajacic v. Blazing Orchards,* 304 Or 436, 746 P2d 218 (1987).

Judicial Review from Workers' Compensation Board.

Submitted on remand January 11, 1988.

Before Richardson, Presiding Judge, and Newman and Deits, Judges.

DEITS, J.

Affirmed.

DEITS, J.

This case is on remand from the Supreme Court for reconsideration in the light of *Gwynn v. SAIF,* 304 Or 345, 746 P2d 218 (1987). We adhere to our former opinion. 84 Or App 127, 733 P2d 113, *modified* 85 Or App 477, 737 P2d 617 (1987).

In *Gwynn*, the claimant had suffered a disabling injury and had entered into a settlement agreement which awarded compensation for permanent partial disability. The issue was whether the claimant's award contemplated future "waxing and waning" of his symptoms and, if so, whether the claimant had established a "worsening" of the condition entitling him to additional compensation.

This case involves a claimant with symptoms that have "waxed and waned"; the issue is whether claimant has proven a worsening. However, the holding in *Gwynn* is inapplicable, because, in contrast to *Gwynn*, where the claimant's injury was disabling and he was awarded permanent partial disability, this claimant's condition was *non*disabling, and he has never received an award of compensation.

Affirmed.

IN THE COURT OF APPEALS OF THE STATE OF OREGON

In the Matter of the Compensation of Archie F. Kephart, Claimant.

EDWARD HINES LUMBER CO.,
Petitioner,

v.

KEPHART,
Respondent.

(WCB 81-0173M; CA A43061)

Judicial Review from Workers' Compensation Board.

Argued and submitted February 5, 1988.

Jerald P. Keene, Portland, argued the cause for petitioner. With him on the brief was Roberts, Reinisch & Klor, Portland.

James L. Edmunson, Eugene, argued the cause for respondent. With him on the brief were Karen M. Werner and Malagon & Moore, Eugene.

Before Warden, Presiding Judge, and Joseph, Chief Judge, and Van Hoomissen, Judge.

PER CURIAM

Affirmed.

PER CURIAM

In this workers' compensation case, the Board, acting on its own motion under ORS 656.278, awarded claimant permanent total disability (PTD) benefits. Employer petitioned for review, and we reversed and remanded the case for reconsideration, because the Board had violated its own rule by not allowing employer 20 days to state its position after claimant had requested own motion relief. *Edward Hines Lumber Co. v. Kephart*, 81 Or App 43, 724 P2d 837 (1986). On remand, after

allowing employer to respond, the Board adhered to and republished its prior order awarding claimant PTD benefits. Employer again seeks review, and we affirm.

Employer first asserts that, due to certain procedural irregularities,[1] its constitutional due process rights were violated. Our earlier remand, however, cured any possible due process problems, because employer was accorded adequate opportunity to, and in fact did, advise the Board of its position in response to claimant's request.

On *de novo* review of the record, we agree with the Board and conclude that claimant is entitled to PTD benefits.[2] ORS 656.206.

Affirmed.

---

[1] In April, 1985, the Board reaffirmed and republished an earlier order that had awarded claimant 75 percent permanent partial disability (PPD) benefits. In May, a state legislator wrote to the Board on behalf of claimant to request elaboration of the Board's reasons for not finding claimant permanently totally disabled and to urge reconsideration of the decision to award only PPD. In response, an administrative assistant to the Board reviewed the file and discussed it with the Board chairman, who explained to the assistant the reasons for the PPD award and, upon request from the assistant, detailed the type of evidence that would cause the Board to find claimant permanently totally disabled. The assistant then contacted claimant by telephone and explained the Board's reasoning and the type of evidence that would be needed for the Board to find him permanently totally disabled. The assistant also "suggested that [claimant] go back to the doctors, explain the type of report he needed and resubmit them [*sic*] to the Board with another request for increased benefits." The assistant also called the state legislator and "reiterated what [he] had told claimant." Claimant again requested own motion relief, supplemented by new medical reports, and the Board granted claimant PTD benefits 13 days later. Our first review of the case followed. *Edward Hines Lumber Co. v. Kephart, supra.* We do not approve of the conduct of the Board's administrative assistant in counseling claimant and the legislator concerning the type of evidence that would persuade the Board to decide in claimant's favor.

[2] Detailing the facts of this case would not aid the Board or the bar. *See Hoag v. Duraflake,* 37 Or App 103, 585 P2d 1149, *rev den* 284 Or 521 (1978).

IN THE COURT OF APPEALS OF THE STATE OF OREGON

In the Matter of the Compensation of Dorla R. George, Claimant.

GEORGE, nka Koelling,
Petitioner,

v.

RICHARD'S FOOD CENTER et al,
Respondents.

(WCB 86-00300; CA A45380)

Judicial Review from Workers' Compensation Board.

Argued and submitted March 29, 1988.

Ralph M. Yenne, Salem, argued the cause and filed the brief for petitioner.

Patric J. Doherty, Portland, argued the cause for respondents. With him on the brief were E. Kimbark MacColl, Jr. and Rankin, VavRosky, Doherty, MacColl & Mersereau, Portland.

Before Warden, Presiding Judge, and Van Hoomissen and Graber, Judges.

PER CURIAM

Affirmed.

PER CURIAM

Claimant seeks judicial review of a Workers' Compensation Board order that affirmed the order of the referee upholding employer's denial of her occupational disease claim. We affirm.

Claimant asks us to remand the case to allow her to supplement the record with her testimony. Because, through her counsel, she agreed to submit the matter to the referee without presenting any testimony, we decline her request.

The petition for judicial review was filed on August 10, 1987, after the effective date of Oregon Laws 1987, chapter 885, and the scope of our review, therefore, is as provided in ORS 183.482(7) and (8). *Armstrong v. Asten-Hill Company,* 90 Or App 200, ___ P2d ___ (1988). The opinion and order of the referee, which the Board approved without opinion, is adequate under the standards of review in ORS 656.298. *Armstrong v. Asten-Hill Company, supra; see also Younger v. City of Portland,* 305 Or 346, ___ P2d ___ (1988).

Affirmed.

IN THE COURT OF APPEALS OF THE STATE OF OREGON

In the Matter of the Compensation of Jimmy Mathis, Claimant.

MATHIS,
Petitioner,

v.

MODOC LUMBER COMPANY,
Respondent.

(WCB 83-10182; CA A40761)

On remand from the Oregon Supreme Court, *Mathis v. Modoc Lumber Company,* 304 Or 436, 746 P2d 218 (1987).

Judicial Review from Workers' Compensation Board.

Submitted on remand January 11, 1988.

Ronald L. Bohy, Salem, for petitioner.

Jerry K. Brown, McMinnville, for respondent.

Before Buttler, Presiding Judge, and Warren and Rossman, Judges.

WARREN, J.

Affirmed.

Buttler, P. J., dissenting.

WARREN, J.

This case is on remand from the Supreme Court for reconsideration in the light of *Gwynn v. SAIF,* 304 Or 345, 745 P2d 775 (1987). Claimant has been awarded benefits totalling 45 percent unscheduled permanent partial disability for a back injury. We affirmed, without opinion, the Board's determination that claimant had not suffered an aggravation so as to qualify for additional benefits under ORS 656.273. 82 Or App 742, 735 P2d 380 (1987).

On remand, the first question is whether the last arrangement of compensation, a stipulation of December 16, 1981, contemplated that claimant would have symptomatic flare-ups of his compensable condition. *Gwynn v. SAIF,* 304 Or at 353. On the basis of medical evidence existing at the time of the stipulation indicating that claimant had "chronic" permanent back pain, we find that the permanent aspects of claimant's injury created a probability that disabling symptoms would come and go and that the stipulation contemplated future flare-ups of symptoms similar to those that led claimant to file this aggravation claim. *See Gwynn v. SAIF,* 91 Or App 84, ___ P2d ___ (1988).

We now address whether claimant is entitled to benefits for his time loss after the last arrangement of compensation. The evidence is that he experienced an episode of pain

and 13 days of total disability after an extended vacation, during which he spent many hours driving in a car. Assuming that the original compensable injury is a material contributing cause of the pain and disability, *see Grable v. Weyerhaeuser Company,* 291 Or 387, 631 P2d 768 (1981), claimant is entitled to benefits for time loss pursuant to ORS 656.273 only if the evidence shows that his condition became worse than that was anticipated at the time of the last award. *Gwynn v. SAIF, supra,* 304 Or at 352. Even assuming claimant's condition "waxed" to the point that he was totally disabled and therefore "worse," *Gwynn v. SAIF, supra,* 304 Or at 352; *but see Gwynn v. SAIF,* 90 Or App 84, ___, ___ P2d ___ (1988) (Warren, J., dissenting), because the award anticipated extensive future periods of disability and because he was disabled from work for only 13 days, he does not qualify for temporary total disability benefits under the analysis in *Gwynn v. SAIF, supra,* 304 Or at 353.

Affirmed.

BUTTLER, P. J., dissenting.

We are directed on remand to determine whether the last arrangement of compensation, a stipulation of December 16, 1981, contemplated that claimant would have symptomatic flare-ups of his compensable condition. *Gwynn v. SAIF,* 304 Or 345, 745 P2d 775 (1987). Although the medical evidence existing at the time of the stipulation indicated that claimant had "chronic" permanent back pain and, in our view and that of the referee and Board, it appeared to contemplate future symptomatic flare-ups, the Supreme Court's opinion requires that there be evidence that the stipulated award specifically took into account anticipated future flare-ups. *Gwynn v. SAIF, supra,* 304 Or at 350. Here, there is no evidence that it did. That it was "knowable" that claimant would have symptoms is not sufficient. Accordingly, I would treat this as an ordinary aggravation claim for benefits for disability not anticipated at the time of the last arrangement of compensation.

The question, then, would be whether claimant is entitled to benefits for time loss after the last arrangement of compensation. The evidence is that he experienced an episode of pain and 13 days of total disability after an extended vacation, during which he spent many hours in a car, and that the original compensable injury is a material contributing cause of his pain and disability. *See Grable v. Weyerhaeuser Company,* 291 Or 387, 631 P2d 768 (1981). Claimant is entitled to benefits for time loss pursuant to ORS 656.273 if the evidence shows that his condition "worsened." *Gwynn v. SAIF, supra,* 304 Or at 352. Because his condition became worse to the point that he was totally disabled, although only temporarily, and because that was not anticipated, his condition "worsened" as a matter of law. *Gwynn v. SAIF, supra,* 304 Or at 352. I would conclude, therefore, that, under the Supreme Court's analysis in *Gwynn,* he is entitled to benefits for temporary total disability.

I would reverse and remand for acceptance of the claim and, therefore, respectfully dissent.

IN THE COURT OF APPEALS OF THE
STATE OF OREGON

In the Matter of the Compensation of
William R. Gwynn, Claimant.

GWYNN,
Petitioner,

v.

STATE ACCIDENT INSURANCE FUND
CORPORATION et al,
Respondents.

(WCB 84-11354; CA A38534)

On remand from the Oregon Supreme Court, *Gwynn v. SAIF*, 304 Or 345, 745 P2d 775 (1987).

Judicial Review from Workers' Compensation Board.

Submitted on remand December 16, 1987.

Ronald L. Bohy, Salem, for petitioner.

Darrell E. Bewley, Assistant Attorney General, Salem, for respondents.

Before Buttler, Presiding Judge, and Warren and Rossman, Judges.

ROSSMAN, J.

Reversed and remanded.

Buttler, P. J., specially concurring.

Warren, J., dissenting.

ROSSMAN, J.

This case is on remand from the Supreme Court for us to determine whether claimant is entitled to additional compensation under the guidelines established in *Gwynn v. SAIF*, 304 Or 345, 745 P2d 775 (1987). We find that he is and, therefore, remand to the Board to determine the amount of that compensation.

Claimant was compensably injured in 1981. In December, 1983, he received an award, based on a stipulation, for 20 percent unscheduled permanent partial disability (PPD). He thereafter worked at a job which required lifting weight greater than that to which his physicians had limited him. As a result, he again became temporarily totally disabled. In our previous opinion, we held that he was not entitled to additional compensation for that temporary disability, because it was anticipated at the time of the last award.

The Supreme Court dealt generally with the question of whether an award of PPD precludes an aggravation award for a "flare-up" of symptoms. It held that a flare-up will entitle a worker to additional compensation if it represents a worsening; that, in turn, will usually depend on what the original award encompassed. However, the court held that, as a

matter of law, there is always a worsening when, as a result of a flare-up, a worker is totally disabled for 14 days or is hospitalized.

The Supreme Court began its discussion by pointing out that the different types of compensable disability are exclusive of each other and that a worker who is temporarily disabled cannot simultaneously also be in a category of permanent disability. As long as the claimant has a temporary disability, there can be no new award of permanent disability. The worker is entitled to additional benefits for permanent disability only if he becomes medically stationary at a level of disability greater than the level of permanent disability for which he has been compensated.

A worker is entitled to additional compensation under ORS 656.273 for worsened conditions since the last arrangement of compensation. If a worker suffers a "waxing" of symptoms of a previously compensated condition which "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." *Gwynn v. SAIF, supra,* 304 Or at 352. (Emphasis supplied.)[1]

If, however, the original PPD award was predicated on an anticipation of some *short* periods of waxing and waning, the Supreme Court held that there is no legal reason to order payment of additional compensation for those periods.[2] "On the other hand, if [the] 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.*" (Emphasis supplied.) *Gwynn v. SAIF, supra,* 304 Or at 353. 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 flare-up that has been taken into consideration by the fixing of the existing award." The court took ORS 656.210(3) as a model:

> "If the worker, as a result of worsening[3] 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 flare-up 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." 304 Or at 353.

---

[1] The court stated, additionally, that, if the waxing falls short of causing total disability, thus preventing a TTD award, but the worker thereafter becomes medically stationary at a greater extent of disability than the previous PPD award, that is also a worsening. *Gwynn v. SAIF, supra,* 304 Or at 352. The court did not state whether a claimant who experiences temporary partial disability would be entitled to benefits for that disability.

[2] The court was not considering medical services under ORS 656.245(1). *See Gwynn v. SAIF, supra,* 84 Or App at 70.

[3] As the court had already said in the opinion, 304 Or at 352, a worker who becomes temporarily totally disabled as the result of a waxing of his symptoms has experienced a worsening.

There are then two questions when a claimant experiences a flare-up after a PPD award. The first is whether the

award contemplated the flare-up. If it did not, it is at least a temporary worsening and is thus an aggravation. Whether the claimant is entitled to additional compensation will depend on whether the flare-up produces temporary total disability and on the claimant's condition after it.[4] The second question arises only if the award did contemplate flare-ups. That question is whether the particular flare-up is greater than what the award contemplated would happen. Although the Supreme Court did not attempt to define every circumstance that would constitute a flare-up greater than contemplated, it did hold that *whenever* a flare-up produces more than 14 days of total disability or requires hospitalization, it is a worsening as a matter of law and the claimant is entitled to additional compensation.

We find, first, that the December, 1983, stipulated award of 20 percent PPD was based on an expectation that claimant would experience a waxing and waning of his condition. Although the stipulation itself does not expressly allocate a portion of the award for anticipated waxing, we assume, in the absence of an indication to the contrary, that the parties considered medical evidence concerning the likelihood that claimant would experience further disabling back symptoms at the time that they reached the settlement. We find, second, that the flare-up in question resulted in total disability for more than 14 days and, thus, necessarily in greater disability than the award contemplated.

Reversed and remanded.

WARREN, J., dissenting.

I agree with the majority that the award contemplated and compensated claimant for future periods of disability. However, I do not understand the Supreme Court's opinion to hold that, *whenever* a claimant experiences time loss or becomes an inpatient in a hospital, he has established an aggravation, and I therefore dissent.

The Supreme Court posed the question as whether an award which contemplates future flareups will preclude an

additional award under ORS 656.273 "for such flareups even if they produce greater disability than that for which the original award was made." *Gwynn v. SAIF, supra,* 304 Or 345, 347, 745 P2d 775 (1987). The court then reaffirmed the rule that a claimant must show that his condition has worsened since the last arrangement of compensation in order to obtain additional benefits under ORS 656.273. 304 Or at 348. As the court emphasized, a mere "waxing," *i.e.*, increase, of symptoms, whether or not anticipated, is not a worsening sufficient to satisfy the requirements for a claim under ORS 656.273, unless it produces *greater disability.* 304 Or at 352. I assume

[4] That there has been an aggravation does not mean that a claimant is automatically entitled to additional PPD benefits once the condition stabilizes. That would require proof that the condition had *permanently* worsened.

that the question of whether there is greater disability is determined by comparing the worker's present condition with his condition at the time of the last arrangement of compensation. 84 Or App at 71. The Supreme Court's opinion appears to say that that is the relevant comparison. Because of the court's repeated emphasis on "worsening" and "greater disability," I would conclude that proof of disability greater than that which existed on the date of the last arrangement of compensation is required to sustain an aggravation claim.

If, for example, a claimant experiences disability which leads to time loss after the last arrangement of compensation, but the last award contemplated that the claimant would have that disability in the normal course of the condition which occasioned the last award, he would not be entitled to additional benefits for temporary total disability, because his disability is no greater than that for which he has already been compensated. That is the case here.

The evidence is that the work leading to the present claim exceeded the limitations placed on claimant at the time of the last award. It was anticipated at that time that he would experience symptoms in the future if he were to exceed those limitations. As the majority found, the last award anticipated that permanent frailty in claimant. The evidence is that he has a permanent disability that becomes symptomatic whenever he does heavy lifting. That disability is not greater than that anticipated at the time of the last award.

I would hold, therefore, that claimant's condition has not worsened so as to entitle him to benefits under ORS 656.273. Rather, he is suffering from a permanent aspect of his

disability, for which he has been previously compensated. I would affirm.

BUTTLER, P. J., specially concurring.

Although I do not agree that the record permits us to find that the December, 1983, stipulated award allocated a portion of the award to anticipated flare-ups, I concur in the majority's disposition of the case.

I do so only because claimant's present disability was total and lasted for more than 14 days, entitling him to additional compensation under *Gwynn v. SAIF,* 304 Or 345, 745 P2d 775 (1987).

IN THE COURT OF APPEALS OF THE
STATE OF OREGON

In the Matter of the Compensation of
Harold Turner, Claimant.
INTERNATIONAL PAPER COMPANY,
Petitioner,
v.
TURNER et al,
Respondents.
(WCB 83-09731; 84-02465; CA A39913)

On remand from the Oregon Supreme Court, *International Paper Co. v. Turner,* 304 Or 354, 745 P2d 780 (1987).

Judicial Review from Workers' Compensation Board.

Submitted on remand December 16, 1987.

Paul L. Roess, Coos Bay, and Foss, Whitty & Roess, Coos Bay, for petitioner.

Michael R. Stebbins, North Bend, and Hayner, Stebbins & Coffey, North Bend, for respondent Harold Turner.

Dave Frohnmayer, Attorney General, Salem, Virginia L. Linder, Solicitor General, and Linda DeVries Grimms, Assistant Attorney General, for respondents Bohemia, Inc. and SAIF Corporation.

Before Buttler, Presiding Judge, and Warren and Rossman, Judges.

ROSSMAN, J.

Reversed and remanded.

Buttler, P. J., specially concurring.

Warren, J., dissenting.

ROSSMAN, J.

This case is on remand from the Supreme Court for a determination of "whether, and on what evidence, the [last award of compensation] was in any part predicated on the anticipated recurrence of symptoms." 304 Or 354, 358, 745 P2d 780 (1987).

Claimant injured his left knee while working as a sander for International Paper Company. In our opinion, 84 Or App 248, 733 P2d 918 (1987), we stated that, before the last arrangement of compensation, claimant had testified at a hearing 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. Also before the last award, Dr. Holbert had reported that, "when [claimant] is active on the [left] knee, it swells up." That evidence was relevant to the question of the extent of permanent disability. The referee's order of April 25, 1983, which is the last award of compensation, is not part of the record, so we do not know whether the referee

expressly allocated a portion of the award for anticipated recurrences of symptoms. We assume, however, in the absence of an indication to the contrary, that all relevant evidence concerning claimant's anticipated permanent disability which was before the referee was considered in making the award of ten percent permanent loss of use of the left leg. If it was not, that was a matter for claimant to challenge on direct appeal of the referee's award to the Workers' Compensation Board. We conclude that the award anticipated that claimant would have future periods of disability, if he became active on his left knee. *See Gwynn v. SAIF*, 91 Or App 84, ___ P2d ___ (1988).

The Supreme Court has ordered us to consider whether, under *Gwynn v. SAIF*, 304 Or 345, 745 P2d 775 (1987), claimant is entitled to benefits for time loss experienced during his employment at Bohemia. Three months after the award, claimant took a job with Bohemia which required him to be on his feet for eight hours. Two weeks after he started working there, he quit because of his left knee symptoms. He has not worked regularly since that time, and he seeks temporary total disability benefits for his time loss.

The evidence shows that the compensable knee injury is a material cause of the present disability. We conclude that claimant is entitled to compensation for his time

loss. Even though the previous award contemplated that he would experience symptoms if he became active on his left knee, a time loss greater than 14 days is treated as a worsening as a matter of law, and he is entitled to compensation for temporary disability and to a reevaluation of the extent of permanent disability when he becomes medically stationary. *Gwynn v. SAIF, supra*, 304 Or at 352.

Reversed and remanded.

BUTTLER, P. J., specially concurring.

I concur for the reasons stated in my specially concurring opinion in *Gwynn v. SAIF*, 91 Or App 84, ___ P2d ___ (1988).

WARREN, J., dissenting.

I dissent for the reasons stated in my dissent in *Gwynn v. SAIF*, 91 Or App 84, ___ P2d ___ (1988).

IN THE COURT OF APPEALS OF THE
STATE OF OREGON

PALMER,
Respondent - Cross-Appellant,
v.
CENTRAL OREGON
IRRIGATION DISTRICT,
Appellant - Cross-Respondent.
(37507-WE; CA A40845)

Appeal from Circuit Court, Deschutes County.

Walter I. Edmonds, Jr., Judge.

Argued and submitted September 21, 1987.

William M. Holmes, Bend, argued the cause for appellant - cross-respondent. With him on the briefs was Gray, Fancher, Holmes, Hurley & Bischof, Bend.

Douglas A. Haldane, Eugene, argued the cause for respondent - cross-appellant. On the brief was Philip H. Garrow, Bend.

Before Richardson, Presiding Judge, and Newman and Deits, Judges.

DEITS, J.

On appeal, judgment for plaintiff on Count I reversed; judgment otherwise affirmed on appeal and on cross-appeal.

DEITS, J.

Defendant appeals and plaintiff cross-appeals in this action arising out of defendant's alleged failure to reinstate plaintiff to his former position or to another position in defendant's employ when he sought to return to work after suffering a compensable injury. Plaintiff states three claims (called "counts" in his pleadings): first, that defendant violated ORS 659.415 by not restoring him to his former position or, if it was unavailable, to another "available and suitable" position; second, that defendant violated ORS 659.410 by discriminating against plaintiff with respect to terms or conditions of his employment, because he had applied for workers' compensation benefits; and, third, that defendant's failure to reinstate plaintiff was based on his having sought benefits and was, therefore, discriminatory and constituted the common law tort of wrongful discharge. The first two claims were tried to the court, ORS 659.121,[1] which ruled in plaintiff's favor on the first and defendant's on the second. The wrongful discharge claim was tried to a jury, which found for plaintiff.

Plaintiff suffered a compensable injury in February, 1981, and was required to miss work for three extended periods between 1981 and 1984. After the last absence, plaintiff

[1] The case was tried before ORS 659.121(2) was amended to allow for jury trials at the request of any party. Or Laws 1987, ch 822, § 1.

sought reinstatement to his former position. Defendant's manager informed plaintiff that that position had been eliminated and that a similar position, which was about to be vacated by another employe, would be converted from permanent to temporary status after the other employe's departure. According to defendant, the elimination of the positions was consistent with an overall objective of reducing its work force. Defendant recommended a number of temporary positions to plaintiff, which he either did not seek or did not accept. In June, 1984, after defendant had made an offer of a temporary position, subject to a posting requirement, plaintiff's attorney wrote defendant and demanded that plaintiff be restored to his former position. The manager then told plaintiff that further communication should be through the parties' attorneys. Plaintiff then brought this action.

Defendant first assigns error to the judgment for

plaintiff on his claim that defendant violated ORS 659.415 by not reinstating plaintiff to his previous position or to another available and suitable one. After this case was tried, the Supreme Court held in *Knapp v. City of North Bend,* 304 Or 34, 741 P2d 505 (1987), that, for a former position to be "available" and subject to the reinstatement requirement of ORS 659.415, it must be in existence and vacant. *Knapp* defeats plaintiff's argument that defendant was required by the statute to restore him to his former position.[2] We are also unable to agree that defendant violated ORS 659.415 by not employing plaintiff in another available and suitable position. We find on *de novo* review that defendant made *bona fide* efforts to find or create such positions for plaintiff and that plaintiff did not accept them. The judgment for plaintiff on his first claim must be reversed.

Defendant's other assignments relate to the wrongful discharge claim. It argues that the court erred, first, by denying its motion for a directed verdict and, second, by giving a jury instruction which defendant maintains there was no evidence to support. We disagree with the first point. As the trial court noted in denying the motion, *inter alia,* the jury could have disbelieved defendant's explanation that its motives for not retaining the permanent status of plaintiff's former position were solely fiscal and could have inferred that that and other actions of defendant were motivated instead by the fact that plaintiff filed a workers' compensation claim. There was evidence enough, including inferences, to enable the jury to find that defendant discriminated against plaintiff because he had sought workers' compensation.

Defendant's other point is more complicated. The challenged instruction was:

> "Failure to reinstate an employe to his regular job or another job that was available and suitable after he returns from disability status because the employee has applied for or utilized the procedures of the [Workers'] Compensation Law constitutes a discriminatory motive. Failure to reinstate an employe for a discriminatory motive constitutes a discharge from employment."

---

[2] As we will discuss in greater detail in connection with defendant's third assignment, however, that does not mean that the failure to reinstate him to the position cannot be redressed under ORS 659.410 or in a wrongful discharge action, if it resulted from a discriminatory motive.

We have concluded that, under the court's interpretation of ORS 659.415 in *Knapp v. City of North Bend, supra*, defendant's failure to reinstate plaintiff did not violate *that* statute. As noted above, *Knapp* was decided after this case was tried and after the parties had filed their briefs on appeal. The grounds for defendant's exception to the instruction in the trial court, as it explains in its opening brief, was that "there is no proof * * * that elimination of the position was because plaintiff had filed a claim for Workers' Compensation benefits." That is the identical point which defendant urged in support of his assignment challenging the denial of its motion for a directed verdict and which we have rejected.

However, in a memorandum of supplemental authorities filed after the Supreme Court's decision in *Knapp v. City of North Bend, supra*, defendant argues that the instruction "is an incorrect statement of law" in the light of *Knapp*. We might be hesitant to hold that defendant's evidentiary exception was inadequate to preserve the legal argument that it now bases on the subsequent Supreme Court decision, *if* any legal deficiency in the instruction could be attributed to what the later decision said. *But see Transpacific Leas. v. Klineline Sand*, 272 Or 133, 535 P2d 1360 (1975). However, *Knapp* has no bearing on the correctness or incorrectness of the instruction here.

It is a *per se* violation of ORS 659.415 not to reinstate an employe when reinstatement is required. A discriminatory motive need not be proved to establish a violation of the statute; correspondingly, a violation of the statute does not *ipso facto* establish a discriminatory motive. Those propositions did not originate with *Knapp*, and *Knapp* did not affect them. The court's holding there related only to ORS 659.415, and it defined when that statute requires reinstatement to a former position. *Knapp* says nothing about the relationship between a statutory violation and the presence or absence of a discriminatory motive.

Although a failure to comply with ORS 659.415 may be probative of discrimination against a worker who has filed a workers' compensation claim, a violation of the statute does not conclusively prove discrimination. However, failure to reinstate a worker who has sought benefits can be discriminatory, even if the refusal to reinstate does not violate ORS

659.415. For example, an employer's elimination of a compensably injured employe's position and its later refusal to restore the employe to the position would not offend ORS 659.415. However, the employer would be guilty of discrimination if its reason for eliminating the position and not reinstating the employe was that the employe had claimed workers' compensation.

The gravamen of plaintiff's wrongful discharge claim was that defendant's refusal to place him in his former position or some other position was motivated by discrimination. Defendant's exception raised only the question of whether there was evidence from which the jury could find in accordance with plaintiff's theory. There is no merit to that exception or to defendant's assignment.[3]

Plaintiff assigns three errors in his cross-appeal. The first two, that the court erred by not ordering reinstatement as a remedy for the violation of ORS 659.415 which it found and also by prorating the attorney fees plaintiff was awarded under ORS 659.121 to reflect only services for the statutory claim on which he prevailed at trial, are mooted by our reversal of the judgment on that claim. He is now entitled to no remedy in connection with ORS 659.415, and he has prevailed on no claim for which attorney fees are awardable. Plaintiff stipulates that his remaining assignment need not be considered if we decide the appeal as we have.[4]

On appeal, judgment for plaintiff on Count I reversed; judgment otherwise affirmed on appeal and on cross-appeal.

---

[3] We do not reach the merits of defendant's legal argument. It is not an anomaly for defendant to be found liable on the wrongful discharge claim, although it is exonerated of violating ORS 659.415 and ORS 659.410, respectively, by our disposition of the first claim and the trial court's unchallenged disposition of the second. The question in the wrongful discharge claim was factual and was tried to a different factfinder than were the other claims. *Holien v. Sears, Roebuck and Co.*, 298 Or 76, 689 P2d 1292 (1984).

[4] He states:

"The court need only reach this assignment of error in the event it finds that the trial court incorrectly held that defendant failed to reinstate plaintiff in violation of ORS 659.415, or if it finds insufficient evidence to uphold the trial court's refusal to direct a verdict in defendant's favor in plaintiff's wrongful termination claim, and if it decides the case must be remanded to the trial court for further proceedings."

IN THE COURT OF APPEALS OF THE STATE OF OREGON

In the Matter of the Compensation of the Beneficiaries of Clinton S. McGill, Deceased.

McGILL,
Respondent,

v.

STATE ACCIDENT INSURANCE FUND CORPORATION,
Appellant.

(85-2-91; CA A44217)

Appeal from Circuit Court, Clackamas County.

Dale Jacobs, Judge.

Argued and submitted February 29, 1988.

Ann Kelley, Assistant Attorney General, Salem, argued the cause for appellant. With her on the briefs were Dave Frohnmayer, Attorney General, and Virginia L. Linder, Solicitor General, Salem.

J. Gary McClain, Milwaukie, argued the cause and filed the brief for respondent.

Before Warden, Presiding Judge, and Van Hoomissen and Graber, Judges.

WARDEN, P. J.

Order awarding claimant $600 as attorney fees vacated.

WARDEN, P. J.

In this workers' compensation case, State Accident Insurance Fund Corporation (SAIF) appeals from a circuit court order awarding attorney fees to claimant under ORS 656.388. Because the court had lost its authority to act in the matter, we vacate the order.

In November, 1981, claimant's husband committed suicide. She filed an occupational disease claim, seeking time loss and medical services benefits for her husband before his death and a claim for widow's benefits. SAIF denied both claims. Claimant requested a hearing, and the referee overruled the denials as to both claims and awarded claimant $4,000 in attorney fees. The Workers' Compensation Board affirmed the compensability of the occupational disease claim, reversed the award of widow's benefits and reduced the award of attorney fees to $2,500.

SAIF did not seek judicial review of the occupational disease claim, and that portion of the Board order became final. Claimant, however, sought judicial review of the Board's disallowance of widow's benefits and, at about the same time, requested, under ORS 656.388(2), that the circuit court determine that she was entitled to $4,000 in attorney fees.[1] In June, 1985, the circuit court fixed the fees at $3,400, 85 percent of the $4,000 requested, on the basis that her attorney had spent 85 percent of his time on the occupational disease claim, on which she had prevailed. The order made no mention of attorney fees for the claim for widow's benefits.

On September 10, 1986, we reversed the Board's decision on the claim for widow's benefits and remanded the case to the Board with instructions to accept the claim. *McGill v. SAIF*, 81 Or App 210, 724 P2d 905, *rev den* 302 Or 461 (1986). On February 9, 1987, after the Supreme Court had denied review, the Board remanded the case to SAIF for acceptance of the claim for widow's benefits. The order made no mention

of attorney fees. On April 2, 1987, claimant asked the circuit court to determine that she was entitled to an additional $600 for attorney fees under ORS 656.388(2) for prevailing on her claim for widow's benefits. SAIF moved to dismiss for lack of jurisdiction on the ground that claimant's request was not filed within 30 days after the Board order. The trial court denied that motion and awarded the requested fee to claimant. SAIF appeals.

[1] ORS 656.388(2) provides:

"If an attorney and the referee or board or appellate court cannot agree upon the amount of the [attorney] 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."

SAIF contends that the court erred in denying its motion to dismiss, citing *SAIF v. Culwell,* 65 Or App 332, 671 P2d 759 (1983), *rev den* 296 Or 411 (1984). We agree. Under ORS 656.388(2), a dispute over attorney fees awarded by the Board must be submitted "forthwith" to the circuit court. In *Culwell,* we held that "forthwith" means within 30 days after the date when the Board issues its order. 65 Or App at 335; *see Ingram v. AMFAC, Inc.,* 73 Or App 197, 199, 698 P2d 493 (1985). Here, claimant submitted the dispute to the circuit court on April 2, 1987, more than 50 days after the Board had issued its order. Even if the date of the Board's order is controlling, claimant waited too long to take the battle to circuit court.

As an alternative ground for awarding the additional attorney fees, the circuit court concluded that it had "continuing jurisdiction" due to the "peculiar circumstances" of this case. We reject that conclusion. Attorney fees in workers' compensation cases may be awarded only when expressly authorized by statute. *SAIF v. Brannon,* 62 Or App 768, 771, 662 P2d 11 (1983). Here, the circuit court order cited no statute or other authority for its "continuing jurisdiction." Claimant has likewise not referred us to any authority, and we have found none.

Order awarding claimant $600 as attorney fees vacated.

IN THE COURT OF APPEALS OF THE
STATE OF OREGON

In the Matter of the Compensation of
William D. Davis, Claimant.

CHAPEL OF MEMORIES et al,
Petitioners,

v.

DAVIS,
Respondent.

(WCB 86-06476; CA A44676)

Judicial Review from Workers' Compensation Board.

Argued and submitted March 2, 1988.

David O. Horne, Beaverton, argued the cause and filed the brief for petitioners.

James L. Edmunson, Eugene, argued the cause for respondent. With him on the brief were Karen M. Werner and Malagon & Moore, Eugene.

Before Warden, Presiding Judge, and Van Hoomissen and Graber, Judges.

WARDEN, P. J.

Affirmed.

Graber, J., concurring in part; dissenting in part.

WARDEN, P. J.

In this workers' compensation case, the Board ordered the claim reopened and the payment of temporary total disability (TTD) benefits. Employer petitions for judicial review, contending that claimant is not entitled to TTD benefits because he has withdrawn from the work force. On *de novo* review, we affirm.

Claimant sustained a low back injury in December, 1982, while working for employer as a grave digger. He has not worked since the injury. In April, 1984, he was awarded 60 percent unscheduled permanent partial disability benefits by a stipulated order. In May, and again in August, 1985, Dr. Smith, a neurologist, requested authorization from employer's insurer, Wausau Insurance Companies (Wausau), to perform lumbar surgery. In October, Wausau denied the compensability of the surgery and also denied claimant's aggravation claim. Claimant requested a hearing and, in March, 1986, a referee upheld the denial of the aggravation claim but set aside the denial of compensability of the surgery. The surgery was performed on May 1. Claimant then sought, and Wausau denied, claim reopening and TTD benefits for the period of his post-surgical convalescence. On August 15, 1986, another referee ordered the claim reopened and awarded TTD benefits, a penalty and attorney fees. Employer requested Board review, and the Board affirmed and adopted the referee's opinion and order.

Employer implicitly concedes that claim reopening was appropriate. Claimant has established that his condition worsened after, and as a result of, the surgery. *See Gwynn v. SAIF*, 304 Or 345, 353, 745 P2d 775 (1987). He is therefore entitled to have his claim processed to closure, when his disability will be reevaluated. ORS 656.268.

The disputed issue is whether claimant is entitled to TTD benefits during his post-surgical convalescence. Employer contends that he withdrew from the work force before his surgery and is therefore ineligible for TTD benefits.[1] To be entitled to TTD benefits, a claimant must suffi-

ciently demonstrate a willingness to seek work. *Cutright v. Weyerhaeuser Co.*, 299 Or 290, 300, 702 P2d 403 (1985).

Claimant is now 63 years old, has an eighth grade education and is hard of hearing. He stopped actively seeking employment in April, 1985. In the March, 1986, hearing, he testified that he had not looked for work since that time, because his back "bother[ed him] so bad [*sic*] that [he] couldn't." He also testified that he was not retired. In the August, 1986, hearing, he again stated that he was not retired

[1] Employer contends that the "retirement" issue was resolved in its favor in the March, 1986, hearing, thus barring relitigation of the issue in the August, 1986, hearing. However, whether claimant had withdrawn from the work force was not an issue in the first hearing. In the opinion and order, the referee stated:

> "I make no prospective decision on whether, if Mr. Davis does elect surgery that I have approved, his condition will have sufficiently worsened as to require reopening, or whether he is otherwise not entitled to time loss at that time."

Claimant was therefore not precluded from litigating the issue in the second hearing. *See Consolidated Freightways v. Poeluijk*, 81 Or App 311, 315, 726 P2d 379, *rev den* 302 Or 299 (1986).

and also expressed his willingness to accept a job within his physical limitations. The medical evidence reveals that his back condition worsened in April, 1985, supporting an inference that he was physically unable to seek employment.[2] Furthermore, his testimony that he had not withdrawn from the work force and would accept suitable employment was uncontroverted. Because that testimony, if believed, would show that he had not withdrawn from the work force, the issue of claimant's credibility is crucially important. Both referees expressly found him credible, and we generally give great weight to the referee's findings with respect to which credibility is an important issue. *Bush v. SAIF,* 68 Or App 230, 233, 680 P2d 1010 (1984).

On the basis of claimant's uncontroverted and credible testimony and the facts and circumstances of this case, we

agree with the referee and the Board and find that claimant had not withdrawn, either voluntarily or involuntarily, from the work force and is entitled to TTD benefits during his post-surgical convalescence.[3]

Affirmed.

GRABER, J., concurring in part, dissenting in part.

I concur in the majority's holding that the claim was properly reopened. However, I do not agree that claimant is entitled to temporary total disability benefits (TTD) and, to that extent, I respectfully dissent.

As the majority recognizes, claimant has the burden to establish his entitlement to TTD. *Smith v. SAIF,* 302 Or 396, 400-01, 730 P2d 30 (1986); *see also* ORS 656.266. He must "prove a willingness to seek work in order to obtain TTD benefits * * *." *Cutright v. Weyerhaeuser Co.,* 299 Or 290, 300, 702 P2d 403 (1985). In my view, claimant failed to carry that burden. Accordingly, I would hold that he withdrew from the workforce before the surgery was recommended or performed and, therefore, that he is not entitled to TTD.

---

[2] In early April, 1985, Dr. Smith examined claimant and noted that his back condition had worsened. Smith recommended a myelogram and a CT scan, which were performed in late April. In May, after reviewing the results of those tests, Smith recommended that a lumbar laminectomy and decompression at L4-5 and L5-S1 be performed. In June, Dr. Matteri, an orthopedist, examined claimant and noted that claimant's back condition had worsened somewhat. Matteri also stated that claimant was not then medically stationary. After reviewing the results of the myelogram and CT scan, Matteri was of the opinion that surgery would not benefit claimant. In August, after reviewing Matteri's reports, Smith reiterated his opinion that the surgery would benefit claimant. As noted, employer denied the compensability of the surgery in October, the referee set aside that denial in March, 1986, and the surgery was performed on May 1. It thus appears that claimant was seeking authorization for the surgery from the time when he stopped seeking employment until it was actually performed.

[3] In his opinion, the referee noted that claimant had applied for Social Security retirement benefits, possibly because we have previously relied on a claimant's application for those benefits as a factor in determining whether, for purposes of workers' compensation law, a claimant had retired. *See Sykes v. Weyerhaeuser Co.,* 90 Or App 41, 750 P2d 1171 (1988); *Karr v. SAIF,* 79 Or App 250, 719 P2d 35, *rev den* 301 Or 765 (1986). The Social Security law contemplates that a person receiving benefits may continue working. At the present time, a person claimant's age (over 62 but not yet 65 years of age) can earn approximately $6,000 annually and still be entitled to full Social Security retirement benefits. *See* 42 USC §§ 402, 403; 20 CFR § 404. The fact that a person has applied for or is receiving Social Security retirement benefits, although relevant, is not wholly dispositive in determining whether the person has withdrawn from the work force for the purposes of workers' compensation law.

The majority relies on four things in reaching the conclusion that claimant remained in the workforce until the time of his surgery: his testimony that he had not "retired"; his testimony that he quit seeking work in April, 1985,[1] because his back hurt; his testimony that he would be willing

to accept a job within his physical limitations; and medical evidence that his back was worse in April, 1985, than in April, 1984, the time of the last arrangement of compensation (60 percent unscheduled permanent partial disability). Those factors do not lead to the majority's conclusion.

First, a claimant can withdraw from the workforce even if he does not consider himself to be "retired." Second, a person who withdraws from the workforce because of his physical condition nonetheless withdraws from the workforce. As we held in *Karr v. SAIF*, 79 Or App 250, 252-53, 719 P2d 35, *rev den* 301 Or 765 (1986):

> "Claimant asserts that he is entitled to time loss, because his retirement was not voluntary in that it was necessitated by his physical condition. Whatever the reason, claimant has withdrawn from the work force. Temporary total disability is awarded for lost wages, *see* ORS 656.210(1), and a person who has withdrawn from the work force has no lost wages. *Cutright v. Weyerhaeuser Co.*, *supra*, 299 Or at 302."

Third, a claimant who passively awaits a suitable job offer is not seeking work.

Finally, I do not agree that the medical evidence supports claimant's decision to cease looking for employment. Nothing in the record suggests that he acted on the advice of a physician, including the surgeon, in stopping his search for work. Although Dr. Smith noted in April, 1985, that claim-

[1] Only by giving claimant the benefit of the doubt can we find that he continued to look for work until April, 1985. At the second hearing, he listed a number of employers with whom he had sought jobs in 1983, 1984, and 1985. Five employers were listed with the notation "85." In the first hearing, claimant testified:

"Q. That's fine. Since April of 19— well, say, since April of 1985 have you been looking for work?

"A. No.

"Q. Why not?

"A. 'Cause my back's been bothering me so bad I couldn't.

"Q. Okay. Are you retired?

"A. Am I retired? Yes.

"Q. Are you retired? I mean —

"A. No. No, I'm not retired.

"Q. Okay.

"A. No. Excuse me. No, I'm not retired. No. * * *

"Q. When did you stop looking for work, sir?

"A. Oh, I'd say it was — oh, I don't know. Probably — oh, I don't know, May or June, someplace in there.

"Q. Of what year?

"A. Of '84.

"Q. So you looked for work a month or two in '84, and then just stopped?

"A. Yeah. It seemed like — can I say more?"

The topic changed at this point in transcript.

The first referee, whose order was not appealed, found that claimant "testified that he looked for work one or two months after April 1984 [the date of the stipulated Determination Order]." Claimant's various statements can be reconciled if he looked for work in 1983 and 1984 and contacted the five employers shown as "85" on the list at some time between January and April, 1985.

ant's back was "worse," there is no indication that he was not well enough to continue to look for light work. Indeed, nearly a year after he had ceased to look for work, the first referee found that the pre-surgery medical evidence did not establish an aggravation of claimant's condition since April, 1984, when he *was* looking for work. The rejection of claimant's applications for Social Security disability benefits before the surgery also suggests that he was not so incapacitated that he could not seek employment within the limits his doctors had specified. He ceased looking for work over a year before the surgery (using the majority's April, 1985, date), during a period when his then treating physician recommended against surgery and before the examining surgeon first suggested the operation.

In short, claimant's credibility does not dispose of the case, as the majority asserts. Even if his testimony is believed, the evidence is in conflict on the issue of withdrawal from the workforce. In my view, although the question is close, the analysis relied upon by the majority is not sufficient to sustain claimant's burden to prove TTD.

IN THE COURT OF APPEALS OF THE STATE OF OREGON

MOORE,
Appellant,
v.
KAISER PERMANENTE et al,
Respondents.
(A8508-04889; CA A41885)

Appeal from Circuit Court, Multnomah County.

Charles Williamson, Judge Pro Tempore.

Argued and submitted July 27, 1987.

Craig D. White, Portland, argued the cause and filed the brief for appellant.

John R. Faust, Jr., Portland, argued the cause for respondents. With him on the brief were Mildred J. Carmack, and Schwabe, Williamson, Wyatt, Moore & Roberts, Portland.

Before Richardson, Presiding Judge, and Newman and Deits, Judges.

DEITS, J.

Reversed and remanded.

DEITS, J.

Plaintiff in this medical malpractice action appeals from a summary judgment for defendant doctors and Kaiser Permanente, the professional corporation of which they are members. He alleges that he suffered a permanent disabling back injury because defendants, who treated him following an on the job injury, were negligent in diagnosing and treating his condition and in advising him that he could return to his bus

driving job after a period of time off. He argues that he raised sufficient issues of material fact to defeat defendants' motion for summary judgment. We reverse and remand.

Defendants moved for summary judgment on the basis of their own affidavits stating that they were not negligent in their diagnosis and advice and that plaintiff's return to work did not cause his condition to worsen. Plaintiff responded with an affidavit in which he states that his condition was "aggravated" by his return to work and the affidavit of his attorney, filed under ORCP 47E,[1] indicating that he had retained an expert who "is available and willing to testify to admissible facts which will create issues of fact as to the diagnoses, standard of care and duty of the defendant herein."

Defendants argue that plaintiff's attorney's affidavit is insufficient to defeat the motion for summary judgment. First, they contend that it does not state, "as the rule requires," that plaintiff's unnamed expert has "actually rendered an opinion or provided facts." Although the rule requires that the affidavit must be "based on admissible facts or opinions obtained from a qualified expert," it does not require that the affidavit recite that the expert rendered an opinion. The rule's requirement that the affidavit be filed in

good faith is intended to ensure that there be an expert opinion on which it is based.

Defendants also contend that the attorney's affidavit is insufficient because it indicates that an expert will testify about "the diagnosis, standard of care and duty," but does not state that expert evidence will be provided to controvert defendants' evidence on damage and causation, the other essential elements of plaintiff's claim. Rule 47E is designed to enable parties to avoid summary judgment on any genuine issue of material fact which may or must be proved by expert evidence. The rule's purpose, essentially, is to permit a declaration by affidavit that evidence will be provided at trial to create an issue of fact. It does not require that the actual evidence be furnished to contravene what the moving party has shown. *Tiedeman v. Radiation Therapy Consultants,* 71 Or App 668, 693 P2d 1396 (1985), *rev'd on other grounds* 299 Or 238, 701 P2d 440 (1985). The affidavit does not have to recite on what issues the expert will testify. It need state only that an expert has been retained and is available and willing to testify to admissible facts or opinions that would create a question of fact.

However, when, as here, the party enumerates those elements on which the unnamed expert will testify, that enumeration would reasonably lead the defendants and the trial

[1] ORCP 47E states:

"If a party, in opposing a motion for summary judgment, is required to provide the opinion of an expert to establish a genuine issue of material fact, an affidavit of the party's attorney stating that an unnamed qualified expert has been retained who is available and willing to testify to admissible facts or opinions creating a question of fact, will be deemed sufficient to controvert the allegations of the moving party and an adequate basis for the court to deny the motion. The affidavit shall be made in good faith based on admissible facts or opinions obtained from a qualified expert who has actually been retained by the attorney who is available and willing to testify and who has actually rendered an opinion or provided facts which, if revealed by affidavit, would be a sufficient basis for denying the motion for summary judgment." (Emphasis supplied.)

court to believe that plaintiff will not be offering expert testimony on the unenumerated elements. We hold that, when a party chooses to enumerate the elements on which an expert will testify, even though a general assertion would otherwise satisfy the rule, the enumeration must give notice of *all* elements on which the expert may testify. Therefore, in this case, plaintiff's attorney's affidavit, alone, is only sufficient to demonstrate that there are genuine issues of material fact on the issues of diagnosis, standard of care and duty or foreseeability.

The remaining question is whether the plaintiff's own affidavit is sufficient to establish that a material question of fact exists as to the other elements he must prove: causation and damages. Defendants contend that plaintiff's own opinion that his condition was aggravated by his work is not competent evidence on those elements, because they are matters on which expert medical evidence is necessary. We cannot say

at this juncture, as a matter of law, that expert medical testimony would be essential for proof of causation and damages. More facts are necessary to assess whether a lay person could determine those issues without expert testimony. OEC 702; *see Getchell v. Mansfield,* 260 Or 174, 179, 489 P2d 953 (1971). Therefore, plaintiff's own affidavit, stating that his condition was aggravated by his return to work, sufficiently raises issues of material fact with respect to causation and damages to defeat defendants' motion for summary judgment.

Reversed and remanded.

IN THE COURT OF APPEALS OF THE
STATE OF OREGON

In the Matter of the Compensation of
the Beneficiaries of Mario Scarino,
Deceased, Claimant.

SCARINO,
Petitioner,

v.

SAIF CORPORATION,
Respondent.

(TP-87002; CA A45358)

Judicial Review from Workers' Compensation Board.

Argued and submitted April 20, 1988.

Robert K. Udziela, Portland, argued the cause for petitioner. With him on the brief was Pozzi, Wilson, Atchison, O'Leary & Conboy, Portland.

Darrell E. Bewley, Assistant Attorney General, Salem, argued the cause for respondent. With him on the brief were Dave Frohnmayer, Attorney General, and Virginia L. Linder, Solicitor General, Salem.

Before Richardson, Presiding Judge, and Newman and Deits, Judges.

RICHARDSON, P. J.

Reversed and remanded.

RICHARDSON, P. J.

Petitioner seeks review of a third party distribution order of the Workers' Compensation Board. She is the surviving spouse of a worker who died of an occupational disease; compensation was paid by SAIF. She was also the personal representative of his estate in Washington. As such, she brought a wrongful death action in the United States District Court for the Western District of Washington against various manufacturers and suppliers of the asbestos which caused the decedent's disease. After she obtained a judgment of approximately $250,000 in that action, she filed a "ratification of covenants and disbursement of funds" in the Washington probate court, proposing to disburse approximately $97,000 of the damages to herself and approximately $16,000 to each of the decedent's adult children. Petitioner is a "beneficiary" under the Oregon Workers' Compensation Law; the parties agree that the adult children are not. ORS 656.005(2); ORS 656.005(5). However, all four are "beneficiaries" of the wrongful death action. RCW 4.20.020. The issue is whether the base amount for calculating the share of the judgment to which SAIF is entitled under ORS 656.593 should or should not include the damages allocated to the children. The Board concluded that it should. We reverse.

ORS 656.580 provides:

> "(1) The worker or beneficiaries of the worker, as the case may be, shall be paid the benefits provided by ORS 656.001 to 656.794 in the same manner and to the same extent as if no right of action existed against the employer or third party, until damages are recovered from such employer or third party.
>
> "(2) The paying agency has a lien against the cause of action as provided by ORS 656.591 or 656.593, which lien shall be preferred to all claims except the cost of recovering such damages."

ORS 656.593(1) provides, as pertinent:

> "If the worker or the beneficiaries of the worker elect to recover damages from the employer or third person, notice of such election shall be given the paying agency by personal service or by registered or certified mail. The paying agency likewise shall be given notice of the name of the court in which such action is brought, and a return showing service of such

> notice on the paying agency shall be filed with the clerk of the court but shall not be a part of the record except to give notice to the defendant of the lien of the paying agency, as provided in this section. The proceeds of any damages recovered from an employer or third person by the worker or beneficiaries shall be subject to a lien of the paying agency for its share of the proceeds as set forth in this section * * *."

Petitioner argues, *inter alia*:[1]

> "[U]nder Washington law, while the right to bring an action for wrongful death vests in the personal representative, benefits of such an action belong to persons designated in the statute as beneficiaries, and the personal representative is merely the statutory agent or trustee acting in favor of the designated statutory beneficiaries * * *.
>
> "[Petitioner] is the sole statutory beneficiary, under Oregon's Workers' Compensation Law, to benefits payable by SAIF. Thus, only her share of the proceeds of the third party judgment is subject to SAIF's lien. The Board erred in distributing to SAIF a portion of the third party judgment that was obtained for the benefit of [decedent's] grown children, who are beneficiaries under the probate laws of the State of Washington, but are not beneficiaries under Oregon's Workers' Compensation Law."

SAIF argues that its lien under ORS 656.580(2) is not against the proceeds received by a particular beneficiary, "but against the cause of action." That argument is premised on less than all of the relevant statutory language. ORS 656.580(2) gives SAIF a "lien against the cause of action *as provided by* ORS 656.591 or *656.593.*" (Emphasis supplied.) ORS 656.593(1) provides that the "proceeds of any *damages recovered* from an employer or third person *by the worker or*

beneficiaries shall be subject to a lien of the paying agency." (Emphasis supplied.)

SAIF also makes a related contention:

> "The total of the proceeds recovered from the third party is subject to the lien, and no part of that recovery can be allocated to persons outside of the workers' compensation system to defeat the lien or any part of it."

SAIF relies on *SAIF v. Cowart*, 65 Or App 733, 738, 672 P2d 389 (1983), where we agreed with the argument that the "statutory scheme does not authorize distribution of any portion of *a claimant's recovery* to a party who, like claimant's wife, has a separate claim outside the workers' compensation system." (Emphasis supplied; footnote omitted.)

In *Cowart*, the worker and his wife brought an action against a third party tortfeasor, stating separate claims for his personal injuries and for her loss of consortium. They sought and obtained SAIF's approval of a $65,000 settlement. *See* ORS 656.587. When the approval was sought and given, it was understood by the parties that the entire amount of the proposed settlement was for the husband's claim. 65 Or App at 736-37. However, he and his wife, together with their attorneys, later decided to "allocate" $15,000 of the settlement to the wife's claim.

[1] Among her other arguments is that the "Board wrongly asserted jurisdiction over proceeds of an estate in Washington" and:

> "The Board, rejecting [petitioner's] position below, wrongfully asserted that because the 'Ratification' filed by [petitioner] in the Probate Court in Washington was not a 'final order' of the Washington Court, but merely her 'desire' to disburse the funds in a particular fashion, it was not usurping the decision of the Washington Probate Court. The Board was wrong, in that pursuant to Washington Law, absent objection within 30 days, a proposed distribution by the personal representative of an estate becomes the final order of the Probate Court, without necessity of the entry of a decree. See RCW 11.68.110."

The grounds for our disposition make it unnecessary for us to reach that argument, and we expressly do not.

There are many differences between this case and *Cowart*. The most salient is that, here, what petitioner did was analogous to what we said that the claimant in *Cowart* could have done but did not:

> "[T]he parties agreed to a settlement of claimant's cause of action for $65,000; he thereafter attempted to change the agreement. *Separate provision could have been made for claimant's wife's claim for loss of consortium prior to the time claimant sought SAIF's approval of the settlement,* but it was not. Claimant's unilateral decision that $15,000 of the proceeds be allocated to her claim came too late." 65 Or App at 738. (Emphasis supplied.)

Under the Washington wrongful death law, RCW 4.20.010 *et seq*, an action may be maintained by a personal representative for the benefit of various persons, including the spouse and children of the decedent. Petitioner was the personal representative as well as a beneficiary of the action.

However, it was only in the latter capacity that she could obtain any personal recovery through the action, and she did not do that until, as plaintiff and personal representative, she allocated or disbursed the proceeds of the judgment to herself and the other beneficiaries of the action.

This case is the converse of *Cowart*. The claimant there sought to divert part of the already ascertained and approved amount of the settlement to his wife. Here, petitioner had obtained no recovery, and her share of the tort judgment was not ascertained until the children's shares of the damages were simultaneously allotted. Those shares were never part of her recovery.[2]

We agree with petitioner's argument, and we conclude that SAIF erred by including the children's damages in the third party distribution calculation. Petitioner asks that the third party distribution order which she proposed "should be ordered by this Court." We consider the more appropriate disposition to be for the Board to make the distribution determination on remand.

Reversed and remanded.

[2] Whether our reasoning reaches beyond the wrongful death action context is a question that we need not now decide. We note, however, that the distinction we have made is not an invitation to gamesmanship, nor is there any basis for believing that gamesmanship occurred here. Indeed, a personal representative who brings a wrongful death action is a trustee for the beneficiaries of the action, *see Gray v. Goodson*, 61 Wash 2d 319, 378 P2d 413 (1963), and has a duty to devise a proper apportionment of the damages among them.

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)

On remand from the Oregon Supreme Court, *Hunter v. Teledyne Wah Chang,* 305 Or 466, 752 P2d 311 (1988).

Judicial Review from Workers' Compensation Board.

Submitted on remand May 3, 1988.

James L. Edmunson and Malagon & Moore, Eugene, for petitioner.

Bradley R. Scheminske and Davis, Bostwick, Scheminske & Lyons, Portland, for respondents.

Before Richardson, Presiding Judge, and Newman and Deits, Judges.

NEWMAN, J.

Affirmed.

NEWMAN, J.

The Supreme Court, 305 Or 466, 752 P2d 311 (1988), reversed and remanded for reconsideration our decision, 88 Or App 282, 745 P2d 427 (1987), in the light of *Georgia-Pacific v. Hughes,* 305 Or 286, 751 P2d 775 (1988). We affirm.

In *Hughes,* the Supreme Court held that we erred in reinstating a penalty for the employer's failure, pending appeal, to pay interim compensation that had been calculated on the full amount of interim compensation that had been awarded, even though the award was for a period that included time during which the claimant was working. The Supreme Court reasoned that "compensation cannot be paid when there is no basis upon which to calculate it," 305 Or at 294, and that, under *Bono v. SAIF,* 298 Or 405, 692 P2d 606 (1984), there was no basis for an award of interim compensation for the period during which the claimant was working. Accordingly, the Supreme Court held that the part of the award of interim compensation for a period when he was working was "never due" under ORS 656.262(10) and, therefore, that the employer should not have been assessed a penalty for failure to pay it pending appeal. ORS 656.313(1).[1]

Applying the Supreme Court's reasoning here, there was "no basis upon which to calculate" the award of interim

[1] In *Hughes,* the Supreme Court confirmed that an award of interim compensation that is "due" must be paid pending appeal. ORS 656.313(1). The claimant there did not seek review of the Board's order which had reduced the interim compensation to cover only the period when the claimant was not working.

compensation to claimant, who never ceased working. *Georgia-Pacific v. Hughes, supra*, 305 Or at 294. Accordingly, the award was "never due" and was not "compensation" within the meaning of ORS 656.313.

Affirmed.

IN THE COURT OF APPEALS OF THE STATE OF OREGON

In the Matter of the Compensation of Thomas E. DeSylvia, Claimant.

DeSYLVIA,
Petitioner,

v.

MULTNOMAH COUNTY SCHOOL DISTRICT #40 et al,
Respondents.

(WCB 84-13344, 82-11158; CA A41813)

Judicial Review from Workers' Compensation Board.

Argued and submitted October 9, 1987.

James L. Edmunson, Eugene, argued the cause for petitioner. With him on the brief was Karen M. Werner, Eugene.

Randy G. Rice, Portland, argued the cause and filed the brief for respondents Multnomah County School District #40, and EBI Companies.

No appearance for respondent SAIF Corporation.

Before Richardson, Presiding Judge, and Newman and Deits, Judges.

DEITS, J.

Affirmed.

DEITS, J.

Claimant seeks review of an order of the Worker's Compensation Board that EBI, and not SAIF, is responsible for claimant's elbow condition. On *de novo* review, we affirm.

Claimant has been a coach and physical education teacher for employer since 1965. In 1966, he severely dislocated his right elbow. After surgery, the claim was closed with an award of 20 percent permanent disability to be paid by SAIF's predecessor. In 1977, claimant injured his upper back during a football drill. As a result, he suffered back pain which radiated to the right hand, with right arm numbness. SAIF accepted the claim as nondisabling, and claimant was found to be medically stationary, without impairment, in November, 1977. EBI was the insurer when, on August 1, 1982, he was again injured during a football practice, experiencing back and neck pain with right arm numbness. X-rays revealed degenerative arthrosis of the elbow; Dr. McNeill, his treating physician, diagnosed ulnar nerve entrapment and recommended surgery.

On November 6, 1982, six days before the scheduled surgery, claimant injured his back when he fell during a demonstration in a wrestling class. He reported pain in his right hand, elbow and shoulder. X-rays were taken, and McNeill concluded that there had been "no acute change in his elbow." This injury was accepted as nondisabling. On November 22, McNeill performed a neurolysis of the ulnar nerve at the right elbow, moving the ulnar nerve anteriorly. The Board agreed with the referee's determination that SAIF, and not EBI, is responsible for the elbow condition, because the sole cause of the need for surgery was degenerative changes related to the 1966 injury. Claimant argues that the Board erred, because the 1982 injuries produced additional injury to the nerve.

Claimant relies on the "presumption" that, when there are multiple accepted injuries involving the same body part, the last injury contributed independently to the condition. *See Industrial Indemnity Co. v. Kearns*, 70 Or App 583, 690 P2d 1068 (1984). The evidence shows that neither 1982 injury contributed to a worsening of the underlying elbow condition. The medical reports after both injuries show no change to the elbow as a result. After the August accident, McNeill diagnosed ulnar nerve entrapment, and that diagnosis did not

change after the November wrestling accident. At that time, McNeill reported no change in the elbow and noted a contusion to the right elbow, with a prognosis that the injury was "self-limiting" and that recovery should be uneventful.

In addition, the evidence shows that claimant had experienced the same problems with his elbow and hand before the 1982 incidents. McNeill indicated that claimant had reported limited motion of his elbow since the 1966 injury and had modified his activities as a result. He had also complained of numbness, tingling and weakness in his right hand beginning in June, before the August incident. He also made similar complaints regarding the arm and hand after the 1977 injury.

Claimant relies on the testimony of Dr. Long, who evaluated his medical progress in December, 1983. Long testified that the 1982 injuries did contribute "something" to the underlying condition. Although McNeill's 1982 report was ambiguous regarding the contribution of the subsequent injuries to claimant's elbow problem, his later reports clarified the ambiguity and concluded that the nerve entrapment was a result of the original injury. We find that conclusion more persuasive than Long's in the light of McNeill's ongoing treatment of claimant.

Affirmed.

IN THE SUPREME COURT OF THE
STATE OF OREGON

SEIBEL,
Petitioner on Review/
Cross-Respondent on Review,
v.
LIBERTY HOMES, INC.,
Respondent on Review/
Cross-Petitioner on Review.

(TC 82-1214; CA A38803; SC S34101, S34152)

In Banc

On review from the Court of Appeals.*

Argued and submitted October 6, 1987.

James L. Francesconi of Francesconi & Cash, P.C., Portland, filed a petition for review and appeared on behalf of petitioner.

G. Kenneth Shiroishi of Dunn, Carney, Allen, Higgins & Tongue, Portland, filed a cross-petition for review and appeared on behalf of cross-petitioner.

LINDE, J.

The decision of the Court of Appeals is affirmed in part and reversed in part, and the judgment of the circuit court is affirmed.

Peterson, C. J., concurred in part and dissented in part and filed an opinion, in which Jones and Gillette, JJ., joined.

* On appeal from a judgment of the circuit court for Yamhill County, Honorable H. W. Devlin, Judge. 85 Or App 261, 736 P2d 578 (1987).

LINDE, J.

Defendant discharged plaintiff from a light duty job that it gave him after he claimed workers' compensation for permanent total disability following an industrial injury. Plaintiff won a jury verdict for damages for breach of an employment contract. On appeal, the Court of Appeals rejected defendant's assertion that there was no evidence of a permanent or "lifetime" employment contract, but the court agreed with defendant that the verdict should be reduced by the amount of social security disability benefits that plaintiff had received and would receive until September 1, 1988, his projected normal retirement date. *Seibel v. Liberty Homes, Inc.*, 85 Or App 261, 736 P2d 578 (1987). Each party petitioned this court to review the ruling adverse to its position. We affirm the ruling that the jury could find breach of a contract of permanent employment, but we reverse the order of remand to offset social security disability benefits.

It would serve little purpose to quote the evidence in detail. Briefly, the disputed terms on which plaintiff was employed emerged from a hearing before a referee considering plaintiff's workers' compensation claim. A determination

order had awarded benefits based on 25 percent unscheduled disability from a low-back injury, and plaintiff claimed that he was entitled to permanent total disability benefits.

At the hearing, defendant's production manager testified that defendant had light work available that plaintiff could perform, primarily driving a forklift. When asked whether "this job that's available for Mr. Seibel, at this time, is a permanent job," the manager answered: "as long as we have production to run." When plaintiff, in turn, was asked whether he would take the type of job that the manager described, he answered that if he could work within his limitations and do no heavy lifting, he "would give it a good try." Plaintiff's compensation award eventually was increased to 40 percent disability.

Plaintiff returned to work for defendant on November 27, 1978. Defendant discharged him on January 26, 1979, on grounds that he did not perform assigned tasks and that other workers complained that he delayed production on which their pay was based, and the present action followed.

Defendant argued that its production manager's statement "as long as we have production to run" meant that a light duty job would exist, not that it would be promised to plaintiff until he retired. The statement could be so understood. But a jury also could find that plaintiff reasonably understood the statement as an assurance that he could return to employment as long as the work he was able to do was needed. Plaintiff was 55 years old at the time, so an inference that the job would last until plaintiff's normal retirement was not unreasonable. We agree with the Court of Appeals that there was some evidence to support the verdict.

Once plaintiff's contract of employment is found to have been breached, however, we do not agree with the court's decision that the amount of the judgment should be reduced by sums that plaintiff later received in social security disability benefits.

Plaintiff applied for disability payments in 1982 and was awarded benefits from and after January 1981. This fact surfaced only late in the trial in a conference in the judge's chambers. The parties disputed whether it should be admitted into evidence, defendant arguing that it was evidence supporting his defense that plaintiff could not do the work, and plaintiff arguing that it was inadmissible evidence of a "collateral source." The court admitted the evidence but instructed the jury not to take it into account in fixing plaintiff's damages, if any; the adjustment would be made by the court. There was no objection to this procedure. After the verdict, however, the court decided that the social security disability benefits should not be deducted from damages and denied defendant's motion to do so.

The remaining issue, therefore, is the purely legal question whether disability benefits under the social security program reduce the liability of an employer who breaches an employment contract. Insofar as there might be an apparent inconsistency between the character of "disability" benefits and the employee's claim that he was able to perform the "light duty" job that he was promised, the jury heard that evidence and decided the issue against the employer.

Whether such payments are to reduce an employer's liability for wrongfully discharging a worker properly depends on the source of the benefits. As a matter only of the common

law of contracts, liability with respect to economic damages would be reduced if the discharged employee finds another job, *see Bramhall v. ICN Medical Laboratories, Inc.*, 284 Or 279, 586 P2d 1113 (1978), Restatement (Second) Contracts § 347 (1979), but statutory benefits often have other characteristics and reflect other policies than the common law of contracts.[1]

The Court of Appeals reduced the employer's liability on the basis of a single precedent, *United Protective Workers v. Ford Motor Co.*, 223 F2d 49 (7th Cir 1955). In that case, an employee's discharge was found to have violated a collective bargaining agreement, and the trial court awarded damages equal to his wages if he had not been discharged. The appellate court observed that if the employer had committed a tort, it could not reduce its liability by any compensation the plaintiff might receive from a third party, but the court thought the rule was otherwise when the discharge was a breach of contract. It explained the distinction on the theory that the tort rule "has a flavor of punitive damages," while in the case before the court, although the employer had breached the contract, "it [was] not a wrongdoer in the tort sense." *Id.* at 54.

Plaintiff attempts to distinguish *United Protective Workers* by drawing a distinction between social security retirement and disability benefits. Unless we were persuaded by that distinction, we might feel constrained to follow *United Protective Workers,* had that decision purported to rest on an interpretation of the Social Security Act. But *United Protective Workers* did not purport to be so based. Rather, the federal court applied what it took to be the common-law contract rule of damages or, more precisely, the federal law of labor agreements under section 301 of the National Labor Relations Act rather than the common law of any state.

We are not persuaded, however, that the effect of payments from a public benefit program on an employer's liability for a wrongful discharge depends on whether the discharge is wrongful as a breach of contract or for some other

reason. That distinction ordinarily has nothing to do with the purposes of such programs. The position urged by defendant and accepted by the Court of Appeals would disregard public compensation in computing damages if the employer wrongfully and tortiously discharges a worker from at-will employment but not if the employer has actually promised the worker a long-term or permanent job.

The distinction finds no support in the policy considerations implicit in public benefit programs such as the social security disability program involved here. Whether the statutory benefit to a discharged worker should reduce the cost to

[1] Defendant also quotes and the Court of Appeals cites *Timberline Equip. v. St. Paul Fire and Mar. Ins.*, 281 Or 639, 646, 576 P2d 1244, 1248 (1978), for the general proposition that "[w]hen a contract is breached the injured party is entitled to receive what he would have if there had been no breach; he is not entitled to receive more." *Timberline* was a dispute about interpretation of a liability insurance policy; the quoted sentence had nothing to do with compensation or any other measure of damages.

the employer of choosing to breach the employment contract is properly an interpretation of the statutory policy. In fact, statutes rarely address the point explicitly, so that court decisions referring only in general terms to a statutory policy "to alleviate the distress of unemployment," *see Century Papers, Inc. v. Perrino,* 551 SW2d 507 (Tex Civ App 1977) (citing other cases), have been criticized for hiding the "opacity" of legislative purposes behind a "rhetorical flourish." Fleming, *The Collateral Source Rule and Contract Damages,* 71 Calif L Rev 56, 79-80 (1983). But the opacity is not impenetrable.

Social benefit payments to adults before normal retirement age ordinarily are a substitute for income usually earned from some private or public employer. Income from employment is the norm, and support from social funds such as unemployment compensation, disability benefits or welfare is intended as an exceptional replacement. Of course, plaintiff's discharge did not cause his disability, but had he remained employed, as defendant promised, he would not have been eligible for disability benefits. If this replacement income from a public benefit program is subtracted from an employer's liability for wrongfully discharging a worker, the employer may calculate that paying only the difference between the worker's wages and the substituted social benefits is the more profitable choice for the enterprise, but its gain comes at the cost of whoever finances the social program.

Of course, the social program may pay the benefits in any event, whether or not the employer's liability is reduced by the amount of the benefits, if the program either does not provide for recapturing the benefits or administrators have not moved to do so when the wrongful discharge claim is tried.

As between the employee and the agency, this may give rise to a question whether an employee in plaintiff's situation may end up with more than his due; but that problem can arise in other three-cornered financial relationships. Seen from the perspective of the employer, subtracting benefits paid to a discharged worker from the employer's contractual liability to that extent reduces the employer's incentive to perform its contract and to keep the worker employed rather than on public welfare or other benefits.

We doubt that legislators enacting such programs mean to adopt the theory that it may be economically more efficient to breach an employment contract and pay damages when the cost of such "efficient" breaches falls on a social benefit program. We also doubt that they meant a liability-reducing effect of social benefits to depend on whether the discharge violates a statute, a contractual promise, or tort law. The effect will be inconsistent with the assumptions underlying the replacement income, unless that program is funded only by the employer or there is evidence of a contrary legislative policy.

Social security is funded by payroll taxes on employers and employees. We do not lay down a single rule for all programs. For instance, the Wisconsin Supreme Court let an employer offset unemployment compensation against damages for breach of an employment contract because the employer would ultimately bear the cost through an increased tax rate. *Dehnart v. Waukesha Brewing Co.,* 21 Wis 2d 583,

124 NW2d 664, 671 (1963). *But compare, e.g., Rutzen v. Monroe Cty Long Term Care Program,* 104 Misc 2d 1000, 429 NYS 2d 863, 865-66 (Sup Ct 1980), *quoting Labor Board v. Gullett Gin Co.,* 340 US 361, 364, 71 S Ct 337, 95 L Ed 337 (1951) (no offset for unemployment benefits); *Brown v. A.J. Gerrard Mfg. Co.,* 715 F2d 1549 (11th Cir 1983); *Green Forest Public Schools v. Herrington,* 287 Ark 43, 696 SW2d 714 (1985); *Lambert v. Equinox House, Inc.,* 126 Vt 229, 227 A2d 403 (1967) (same). Moreover, programs differ in the speed and finality of their benefit determinations. Some potential claims may not even have been filed by the time the worker's case against the employer is tried, or a claim may have been accepted at one level only to be later rejected at a higher level, or it may have been rejected and appealed, or benefits may be redefined or recalculated. These exigencies of social benefit

administration should play no role in the employer's liability for wrongfully discharging an employee. A trial of the employee's contract action should not be turned into a trial of the employee's potential claims for benefits from some administrative program, nor should the outcome depend simply on whatever cash benefits happen to have been paid before the trial.

It is argued that to disregard payments of social benefits in the action against the employer gives a successful plaintiff an unjustified windfall. But whether to save or recapture those costs is properly an issue between the provider of the benefits and its beneficiaries, a policy choice in the design of the program. Absence of a recoupment provision does not help the employer who causes the costs by improperly terminating the employee's regular source of compensation. *See Rutzen, supra,* 429 NYS 2d at 866; Note, *Mitigation of Damages by Social Welfare Benefits,* 48 B U L Rev 271, 280-82 (1968).

The Legislative Assembly recently enacted that civil damages for bodily injury or death may be reduced by benefits received from someone other than the party who is to pay the damages, with exceptions that include "(d) Retirement, disability and pension plan benefits, and federal social security benefits." ORS 18.580. The statute does not directly apply, but our holding today is consistent with its policy toward the treatment of benefits replacing economic loss.

For the foregoing reasons, we conclude that the circuit court was right not to reduce plaintiff's damages by the amount of his social security disability benefits.

The decision of the Court of Appeals is affirmed in part and reversed in part, and the judgment of the circuit court is affirmed.

PETERSON, C. J., concurring in part and dissenting in part.

Only by indulging in the most liberal interpretation of the evidence can it be said that there was sufficient evidence from which a jury could find that a contract for lifetime employment existed between the plaintiff and the defendant. Because the plaintiff is entitled to a liberal interpretation of the evidence, I concur with the majority on this issue. I dissent

from the majority's conclusion that social security disability benefits should not be offset.

The issue is whether the plaintiff's award for breach of the employment contract should be reduced by sums that the plaintiff received in social security disability benefits. The plaintiff applied for disability payments in 1982 and was awarded benefits from and after January 1981.

The record shows that at the time of trial the plaintiff was receiving social security benefits for disability under 42 USC § 423(d)(1), which provides:

"The term 'disability' means—

"(A) inability to engage in any substantial gainful activity by reason of any medically determinable physical or mental impairment which can be expected to result in death or which has lasted or can be expected to last for a continuous period of not less than 12 months * * *."

20 CFR § 404.1505(a) defines "disability" as follows:

"The law defines disability as the inability to do any substantial gainful activity by reason of any medically determinable physical or mental impairment which can be expected to result in death or which has lasted or can be expected to last for a continuous period of not less than 12 months. To meet this definition, *you must have a severe impairment, which makes you unable to do your previous work or any other substantial gainful activity which exists in the national economy.*" (Emphasis added.)

The evaluation of a disability claim is controlled by 20 CFR § 404.1520, which in part provides:

"(a) *Steps in evaluating disability.* We consider all material facts to determine whether you are disabled. If you are doing substantial gainful activity, we will determine that you are not disabled. * * *.

"(b) *If you are working.* If you are working and the work you are doing is substantial gainful activity, we will find that you are not disabled regardless of your medical condition or your age, education, and work experience.

"* * * * *

"(e) *Your impairment(s) must prevent you from doing past relevant work.* * * *."

"(f) *Your impairment(s) must prevent you from doing any other work.* * * *." (Emphasis added.)

At trial of the instant case, the social security issue arose in this manner. Near the end of the case, the plaintiff's attorney, in a chambers conference, volunteered that the plaintiff was receiving social security disability benefits. A discussion ensued concerning whether the evidence was admissible. The defendant's attorney asserted that the evidence supported his defense that the plaintiff was unable to work and was admissible. The plaintiff's attorney argued that the evidence was inadmissible "as a collateral source." The court ruled that the evidence would be admitted.

On the question of whether the disability benefits

received could be used to reduce the plaintiff's damages, the court instructed the jury:

> "Now, you have heard testimony in this case about the plaintiff's Social Security benefits and what he's received therefrom, and what he may receive therefrom. However, now, if you find the plaintiff is entitled to recover, you should determine what his total damages were under the test or measure that I just gave you without any reduction for Social Security benefits received or to be received. The Court will adjust your award to allow for such benefits."[1]

Following the return of the verdict for the plaintiff, the defendant moved the court for an order reducing the damages "by the amount of benefits plaintiff has received in the form of Social Security Disability payments and the amount he will receive in the future of such disability payments." The motion was denied. This appeal followed.

As a general rule, recovery of damages for tortious injury is intended to restore the injured party to the position enjoyed before the injury or to compensate the injured party

for the loss. *See, e.g., United Engine Parts v. Reid,* 283 Or 421, 584 P2d 275 (1978). Recovery for breach of contract is intended to put the plaintiff in the position he or she would have been had there been no breach. *See, e.g., Timberline Equip v. St. Paul Fire and Mar. Ins.,* 281 Or 639, 646, 576 P2d 1244 (1978).

This action is for breach of an employment contract. Damages in such cases generally are measured by the accrued wages to the time of trial plus the present value of the total future lost wages for the unexpired term of the employment term, less amounts actually earned in other employment or amounts which could have been earned in other employment by the exercise of reasonable effort. *Bramhall v. ICN Medical Laboratories, Inc.,* 284 Or 279, 286-87, 586 P2d 1113 (1978); 5 Corbin on Contracts 514-518, § 1095 (1964). Under this rule, had the plaintiff obtained other employment, the earnings from that employment would be deducted from the amounts otherwise payable under the contract.

The majority errs in holding that damages for breach of an employment agreement should not be reduced by the amount of social security *disability* benefits received by the plaintiff.

We start with the premise that in an action for breach of contract the plaintiff is entitled to be made whole; he is entitled to be put in as good a position as he would be had the contract been performed. Consistent with this rule, earnings from other employment are deductible from the amount promised to the plaintiff. Whether viewed as an avoidable consequence or as mitigation of damages, that is the rule.

In this case, if no deduction is made from the award,

[1] The better practice would be for the jury to decide all damage questions under appropriate instructions. As the trial court ruefully observed near the end of the case,

> "See, you are putting me in a hell of a bind. You are throwing this at me right now. I've got to make a quick decision. I don't like that."

The record suggests that the source of the court's instruction was a handwritten requested instruction by one of the attorneys. (The handwritten requested instruction is not in the trial court file.) In any event, the instruction was given, the procedure described was followed, no objection was made to the procedure and no exception was taken to the instruction.

the plaintiff will be made whole and then some, the "then some" being the amount of the social security *disability* benefits.

I am persuaded that an offset should be made for social security disabiity benefits. If the disability payments are not deducted, the plaintiff will receive a double recovery and will be placed in a better position than had the contract been performed. *See United Protective Workers v. Ford Motor Co.*, 223 F2d 49 (7th Cir 1955). The regulations quoted above make it clear that if the plaintiff had been working for the

defendant, he would not have been entitled to the social security disability benefits.[2] Had the plaintiff, after breach of the contract by the defendant, become disabled and unable to work, he would not have been entitled to receive payment from the defendant after the date of disability.[3]

Even allowing an offset, the plaintiff will be made whole. The plaintiff is put in the position he would have been had the contract been performed. The law's interest in preventing double payment is met, and not unfairly. The law's interest in full compensation is met, and not unfairly.

The collateral source rule, not referred to by name in the majority opinion, is an exception to the general principles that hold that the plaintiff is entitled to be compensated for his or her actual loss and no more. The reasoning is that the defendant, in acting tortiously and causing injury, is a "wrongdoer" and should not reap the benefits of or be credited with money or services *received as a result of the injury from sources other than the wrongdoer. Reinan v. Pacific Motor Trucking Co.*, 270 Or 208, 213, 527 P2d 256 (1974); *Cary v. Burns*, 169 Or 24, 28-9, 127 P2d 126 (1942).

Heretofore this court has applied the collateral source rule only in the tort context. *See e.g. Reinan v. Pacific Motor Trucking Co.*, 270 Or at 213; *Peterson v. State Farm Ins. Co.*, 238 Or 106, 114-15, 393 P2d 651 (1964); *Cary v. Burns, supra.* That is because application in the context of contracts is inconsistent with the rationale for the rule. As stated above, in an action for breach of contract, the law aims to place the party injured by the breach in the position he or she would have been had the other party performed by means of a judgment for money. He or she is not entitled to receive more.

Timberline Equip v. St. Paul Fire and Mar. Ins., supra, 281 Or at 646; *Selman v. Shirley*, 161 Or 582, 91 P2d 312 (1939).

Note the emphasized language: benefits "received as a result of an injury from sources other than the wrongdoer." In tort cases, the defendant will not be credited for benefits

[2] I emphasize that this case involves social security *disability* benefits. Whether the same result would apply to social security retirement benefits or unemployment compensation benefits is not involved in this case.

[3] The editors of Restatement (Second) Contracts give this example:

> "On April 1, A and B make a personal service contract under which A is to employ B for six months beginning July 1 and B is to work for A during that period. On May 1, B repudiates the contract. On August 1, B falls ill and is unable to perform the contract for the remainder of the period. A can only recover damages based on his loss during the month of July since his loss during subsequent months was not caused by B's breach. * * *"

Id., § 347, *illustration 15* at 117.

received from other sources *as a result of an injury* from other sources. (This premise is carried into newly enacted ORS 18.580. It uses the phrase "when * * * the party awarded damages * * * *received benefits for the injury* * * * other than from the party who is to pay the damages * * *.") The disability benefits were not received "as a result" of the defendant's breach of contract. The collateral source rule isn't a player in this case.

The majority states:

> "We are not persuaded, however, that the effect of payments from a public benefit program on an employer's liability for a wrongful discharge depends on whether the discharge is wrongful as a breach of contract or for some other reason."

305 Or at 366 (1988). Wrongful conduct is the reason we have previously given for not allowing an offset for other benefits received. Why does the majority depart from that reasoning?

The majority goes on to say that whether the benefit "should reduce the cost to the employer of choosing to breach the employment contract is properly an interpretation of the statutory policy." 305 Or at 367 (1988). If anything is clear from the social security legislation quoted above, it is that a worker should not, at the same time, receive compensation for working and compensation for social security disability benefits.

The majority also opines:

> "Seen from the perspective of the employer, subtracting benefits paid to a discharged worker from the employer's contractual liability to that extent reduces the employer's incentive to perform its contract and to keep the worker employed rather than on public welfare or other benefits."

305 Or at ___ (1988). The majority refers to the fact that "it may be economically more efficient to breach an employment contract and pay damages when the cost of such 'efficient' breaches falls on a social benefit program." 305 Or at ___

(1988). Those may be pertinent comments in another case, but they do not apply here.

This is not a case where the employer's breach foisted anything onto the social security disability program. The benefits were not paid because of the breach. Indeed, the possibility of such benefits being paid was not contemplated by the employer.

This is a case in which the integrity of the judicial system should be considered. The plaintiff claimed damages from the defendant on the theory that he was "ready, willing and able to perform the contract." It is clear from the social security regulations that the premise for his receipt of disability benefits is that he was "unable to do any substantial gainful activity." Beyond question, there is an irreconcilable factual and legal inconsistency in these claims.

I suggest that the integrity of the judicial process requires an offset. By not allowing an offset, we are putting our imprimatur, our approval, on assertions that are more than arguably flatly inconsistent. In a very real sense, we are saying, "Plaintiff, you are entitled to social security benefits

because you are unable to do any substantial activity; and you are nonetheless entitled to damages from the defendant, even though you could not have performed your contract with the defendant."

One premise for the majority's result in this case is that the breaching employer should not be able to foist onto social security or unemployment compensation the cost of its breach of contract. Whatever validity that premise has, it isn't this case. The opinion encourages conduct that should be discouraged. I have no quarrel with rules of procedure that permit the assertion of inconsistent theories and the presentation of inconsistent facts. But no court should make or approve an *award* that is premised upon inconsistent facts or inconsistent theories of recovery.

The best result is this: We should make the plaintiff whole. Let the plaintiff keep his damage award (which is based upon the premise that he can work), but subtract from that the "damages" he has already received (based on the premise that he can't work). This result is fair, and does no disservice to the policy arguments invoked by the majority.

From our opinions reaching back over twenty years, and most emphatically in the last two years, one must conclude that this court understands the inherent limitations of the judiciary to engage in social engineering. We have said that one should not be tempted to "explain the court's understanding of the existing state of the law by the court's views of desirable social policy." *Norwest Presbyterian Intercommunity Hosp.*, 293 Or 543, 553, 652 P2d 318 (1982). *Accord Donaca v. Curry Co.*, 303 Or 30, 35-6, 36 n 5, 734 P2d 1339 (1987); *Winn v. Gilroy*, 296 Or 718, 728, 681 P2d 776 (1984); *Wights v. Staff Jennings*, 241 Or 301, 310, 405 P2d 624 (1965). That is what the majority does today.

This is not a case of tortious discharge from employment. Two parties disagree on whether there exists a contractual obligation on the part of the defendant to employ the plaintiff under a lifetime contract. The terms of the contract before this court, as stated by the majority, are these: "this job that's available for Mr. Seibel, at this time, is a permanent job" "as long as we have production to run." The plaintiff gave up no right by returning to work. He continued to assert to the Workers' Compensation Board that he was totally disabled. The majority must agree that such terms could leave some doubt in the minds of all concerned that the plaintiff had a lifetime contract. To dispute the existence of such a contract is not some type of "bad faith." I very much doubt that the legal significance of these terms was apparent to anyone (with the possible exception of the plaintiff's attorney) at the time of the workers' compensation hearing.

If the defendant did in fact tortiously discharge the plaintiff or is otherwise guilty of deceit in offering the plaintiff a position that the plaintiff could not handle, then the plaintiff could have brought an action in tort. An attorney often must make decisions concerning the theory of liability to be asserted. Sometimes the tort measure of damages is more favorable than the contract measure. Oftentimes it is easier to prove one theory than another — for example, strict tort

liability and negligence. Alternatively, the plaintiff could have argued that the employer acted in bad faith, that in this particular case the reaching party is in that sense a wrongdoer and is not entitled to an offset. These issues are not in the case. The majority should avoid the temptation to fashion a

rule for all times and all purposes to avoid a perceived injustice in this case.

This is not the case to graft a tort measure of damages onto a cause of action for breach of contract. Nor does this case occasion us to examine the theory of efficient breach, the doctrine of bad faith breach, negligent breach or tortious breach, or to reexamine the collateral source rule in tort cases.[4] It is a straightforward claim for breach of contract.

Jones and Gillette, JJ., join in this opinion.

---

[4] *See* The Economics of Contract Law (A. Kronman & R. Posner eds 1979); Barton, *The Economic Basis of Damages for Breach of Contract*, 1 J Legal Stud 277 (1972); Shavell, *Damage Measures for Breach of Contract*, 11 Bell J Econ 466 (1980); Note, *Tort Remedies for Breach of Contract: The Expansion of Tortious Breach of the Implied Covenant of Good Faith and Fair Dealing Into the Commercial Realm*, 86 Colum L Rev 377 (1986); Note, *Damage Measurements for Bad Faith Breach of Contract: An Economic Analysis*, 39 Stan L Rev 161 (1986).

On the collateral source rule in contract cases, see Fleming, *The Collateral Source Rule and Contract Damages*, 71 Cal L Rev 56 (1983).

On mitigation of damages by social welfare benefits, see *Fleming, supra;* Note, *Mitigation of Damages by Social Welfare Benefits*, 48 B U L Rev 271 (1968).

IN THE SUPREME COURT OF THE STATE OF OREGON

In the Matter of the Compensation of Dawn White, Claimant.

NORTH CLACKAMAS SCHOOL DIST.,
Respondent on Review/
Petitioner on Reconsideration,

v.

WHITE,
Petitioner on Review/
Respondent on Reconsideration.

(WCB 83-09151; CA A36411; SC S34192)

In Banc

On petition for reconsideration of decision filed February 17, 1988.*

Jerald P. Keene, of Roberts, Reinisch & Klor, P.C., Portland, for respondent on review/petitioner on reconsideration.

Donald E. Beer, of Galton, Popick & Scott, P.C., Portland, for petitioner on review/respondent on reconsideration.

PETERSON, C. J.

Petition for reconsideration allowed. Opinion modified. The decision of the Court of Appeals is reversed. The case is remanded to the Court of Appeals to decide whether the insurer's denial of the need for further medical care and treatment for the claimant's hip condition was proper.

---

* 305 Or 48, 750 P2d 485 (1988)

PETERSON, C. J.

In this workers' compensation case, the employer seeks reconsideration. It asserts: (1) that the issue before the Court of Appeals and this court on the employer's appeal and petition for review concerned only the claimant's claim for medical services for a hip condition, that no worsening claim is involved, and that we erred in stating and deciding that a worsening claim was involved; and (2) that "the Court of Appeals properly found an identity of factual issues sufficient to warrant application of the res judicata principles this Court itself has now adopted in Workers' Compensation cases," and that we erred in holding that the Court of Appeals erred in applying res judicata to the claim for medical treatment of the hip injury. The employer's first assertion is correct; its second assertion is not.

No worsening claim is involved, and we erred in stating that one was. This case now involves only the claimant's claim for medical expenses for the hip injury.

We should have concluded our earlier opinion as follows (these three paragraphs replace the last three paragraphs of the opinion):

> "The Court of Appeals' opinion seems to say that as a matter of law *all* of the claimant's claims, including the claim for medical expenses, are barred under the rules of res judicata. The finding of no permanent partial disability at the first decision does not bar all claims for medical benefits under rules of res judicata. We read the first Board decision to find a hip injury, but no then present permanent partial disability. If the later medical benefits claim is uncompensable, it is uncompensable because, as a matter of fact, medical evidence fails to show a causal relationship between the industrial accident and the present need for medical care.
>
> "Though we agree with the Court of Appeals that a claimant 'cannot use an aggravation claim as a back door to relitigate underlying causation issues,' 85 Or App at 563-64, that is not the case here. The finding of no permanent partial disability at the first hearing did not bar the assertion of all later medical expense claims as a matter of law.
>
> "The decision of the Court of Appeals is reversed. The case is remanded to the Court of Appeals to decide whether the insurer's denial of the need for further medical care and treatment for the claimant's hip condition was proper."

Petition for reconsideration allowed. Opinion modified. Remanded to the Court of Appeals.

IN THE SUPREME COURT OF THE STATE OF OREGON

In the Matter of the Compensation of Leokadia W. Piwowar, Claimant.

GEORGIA-PACIFIC CORPORATION,
Petitioner on Review,

v.

PIWOWAR,
Respondent on Review.

(WCB 82-09391; 83-07720; CA A38112; SC S34285)

In Banc

On review from the Court of Appeals.*

Argued and submitted November 3, 1987.

George W. Goodman, McMinnville, argued the cause for petitioner on review. On the petition were Jerry K. Brown and Cummins, Cummins, Brown, Goodman & Fish, P.C., McMinnville.

Linda C. Love, of Francesconi & Associates, P.C., Portland, argued the cause and filed the response for respondent on review.

CAMPBELL, J.

The decision of the Court of Appeals is affirmed in part and reversed in part. The decision of the Workers' Compensation Board on reconsideration in WCB Case No. 82-09391 is affirmed. The decision of the Workers' Compensation Board in WCB No. 83-07720 is affirmed.

* Judicial Review of Order of the Workers' Compensation Board. 86 Or App 82, 738 P2d 225 (1987)

CAMPBELL, J.

The issue in this case is whether a workers' compensation insurer may cease paying the compensation awarded in a determination order pending a hearing on that order.

Leokadia Piwowar worked for the Georgia-Pacific Corporation (Georgia-Pacific), a self-insured employer. In August 1981, Piwowar reported to her employer that she strained her back during work. She was unable to work after this incident. Piwowar's workers' compensation claim form[1] lists her injury as a "sore back." Georgia-Pacific accepted the claim.[2]

By late 1982, Piwowar's condition was stationary and her claim was submitted to the Evaluations Division of the Workers' Compensation Department for closure. The Evaluations Division determined that Piwowar's injury resulted in a 40 percent permanent partial disability valued at $10,880 and Georgia-Pacific began paying the award. Piwowar requested a hearing on the extent of her disability. Georgia-Pacific did not request a hearing.

After the Evaluations Division issued its determination order, Georgia-Pacific learned that Piwowar's back problems may have arisen from a disease known as ankylosing spondylitis, which was unrelated to her employment and therefore not compensable. Georgia-Pacific issued a "partial denial" of the ankylosing spondylitis condition and unilaterally terminated the permanent partial disability payments which it had been making pursuant to the determination order.

A Hearings Division referee upheld the partial denial and struck the award for permanent partial disability, finding that the noncompensable ankylosing spondylitis caused the disability.[3] He concluded that the denial did not authorize Georgia-Pacific to terminate the payments awarded in the determination order and ordered Georgia-Pacific to pay the amount due under the determination order from the date of the partial denial to the date of the hearing. The referee also assessed a penalty and attorney fees (WCB Case No. 82-09391).

Georgia-Pacific refused to pay the award in the referee's order and requested the Workers' Compensation Board (Board) to review the referee's decision. The Board first upheld the denial, but it reversed the referee's order to pay the amount due under the determination order. On reconsideration, the Board disallowed the denial and affirmed the rest of the referee's decision.

In a second hearing (WCB Case No. 83-07720), a referee found that Georgia-Pacific should have paid the amount ordered in the first hearing while the appeal of that order was pending. However, the referee did not penalize Georgia-Pacific for refusing to pay the first order pending appeal. On review of the order in the second hearing, the Board upheld the referee's decision that payment was not stayed pending appeal, but the Board assessed penalties and

[1] A brief summary of the procedures for resolving workers' compensation claims may help clarify the issues in this case. When a worker presents a claim for workers' compensation, the employer's insurer must notify the claimant within 60 days that the insurer either accepts or denies the claim. The notice must also advise the claimant whether the insurer considers the injury disabling or nondisabling. ORS 656.262(6). A nondisabling injury is an injury which requires medical services only, ORS 656.005(7)(c), but a disabling injury entitles the worker to death or disability benefits. 656.005(7)(b). The claimant may request a hearing on a denial and on whether the injury is disabling. ORS 656.283.

A claim for a compensable disabling injury must be closed once the claimant's condition is medically stationary. ORS 656.268. Closing claims is usually the responsibility of the Evaluations Division of the Department of Insurance and Finance. ORS 656.268(4). (When Piwowar's claim was closed, the Evaluations Division was part of the Workers' Compensation Department. *Former* ORS 656.268, *amended by* Or Laws 1987, ch 884, § 10; OAR 436-30-005.) The Evaluations Division closes claims by issuing a determination order awarding compensation based on the extent of the claimant's permanent disability. ORS 656.268(4); OAR 436-30-010. To contest a determination order, either party may request reconsideration by the Evaluations Division, ORS 656.268(4), or request a hearing, ORS 656.283.

[2] From the record, it is difficult to ascertain the nature of the employer's acceptance. However, Georgia-Pacific has admitted throughout these proceedings that it accepted the claim as submitted, and the Court of Appeals based its decision on acceptance of a sore back claim. *Georgia-Pacific v. Piwowar*, 86 Or App 82, 85, 738 P2d 225 (1987).

[3] The referee treated Georgia-Pacific's denial as a cross-request for a hearing which placed the compensability of the ankylosing spondylitis at issue. Piwowar contends that the referee erred in treating the denial as a hearing request and therefore lacked authority to reduce the permanent partial disability award. However, Piwowar did not seek judicial review of the Board's order affirming the referee's conclusion that the ankylosing spondylitis is not compensable, so we need not address whether the ankylosing spondylitis is compensable and whether that issue was properly before the Board. *See Georgia-Pacific v. Piwowar*, 86 Or App 82, 85, 738 P2d 225 (1987).

attorney fees based on the amount in the first order less the penalty and attorney fees awarded in the first order.

Georgia-Pacific then sought judicial review of both decisions of the Board. The Court of Appeals applied this court's recent decision in *Johnson v. Spectra Physics,* 303 Or 49, 733 P2d 1367 (1987), and held that Georgia-Pacific properly denied the compensability of the ankylosing spondylitis condition. However, the court concluded that Georgia-Pacific's denial did not terminate its obligations under the determination order. Because it viewed Georgia-Pacific's unilateral termination of disability payments as unreasonable, the Court of Appeals upheld the Board's award of a penalty and attorney fees as well as the additional penalty for Georgia-Pacific's failure to pay the first referee's award pending appeal. *Georgia-Pacific v. Piwowar,* 86 Or App 82, 738 P2d 225 (1987).

The issues in this case are whether Georgia-Pacific was authorized to terminate the payments awarded in the determination order and whether it was proper to penalize Georgia-Pacific for failing to pay the award of the determination order and for failing to pay the referee's order from the first hearing. Although we disagree with the Court of Appeals' analysis of *Johnson,* we hold that Georgia-Pacific could not unilaterally terminate payments ordered by the Evaluations Division and that penalties and attorney fees are appropriate.

I. FAILURE TO MAKE PAYMENTS AWARDED IN THE DETERMINATION ORDER

Georgia-Pacific contends that once it denied the compensability of the ankylosing spondylitis condition, it was no longer obligated to pay the compensation awarded for that disability. To support its contention, Georgia-Pacific relies on ORS 656.262(2), which provides:

> "The compensation due under this chapter shall be paid periodically, promptly and directly to the person entitled thereto upon the employer's receiving notice or knowledge of a claim, *except where the right to compensation is denied by the insurer or self-insured employer.*" (Emphasis added.)

The Court of Appeals held that ORS 656.262(2) does not authorize terminating payments upon denial of compensability because that provision speaks to "when the duty to

pay benefits *does not begin,* not with when it ends[.]" *Georgia-Pacific v. Piwowar, supra,* 82 Or App at 85 (emphasis in original). When the court decided that issue it did not have the benefit of our recent opinion in *Georgia-Pacific v. Hughes,* 305 Or 286, ___ P2d ___ (1988), where we stated that an insurer may, pursuant to ORS 656.262(2), suspend payments of compensation once it denies the claim. Because a valid denial would suspend Georgia-Pacific's duty to pay, we must determine whether Georgia-Pacific's denial of the compensability of the ankylosing spondylitis was valid in light of the previous acceptance of the sore back claim.

In the absence of fraud, misrepresentation or other illegal activity, an insurer who accepts a claim for compensa-

tion may not later deny the same claim. *Bauman v. SAIF*, 295 Or 788, 794, 670 P2d 1027 (1983). The insurer in *Bauman* specifically accepted the employee's claim for a bursitis condition and began making payments. When the claimant sought to reopen his claim to secure compensation for additional medical treatment, the insurer attempted to deny the compensability of the initial injury. This court reasoned that allowing the insurer to deny a previously-accepted claim would "encourage degrees of instability in the workers' compensation system that we do not believe the statute contemplates[,]" and the potential for delayed litigation would frustrate the statutory scheme's provision for "a speedy resolution of workers' compensation claims." 295 Or at 794.

Application of the *Bauman* rule was refined in *Johnson v. Spectra Physics*, 303 Or 49, 733 P2d 1367 (1987). In *Johnson* the claim form listed the nature of claimant's injury as a "back injury" located in the "middle back and arm." The insurer accepted the claim on the same form. A physical examination revealed that the claimant suffered from a back injury and carpal tunnel syndrome, which is a wrist affliction. The insurer then notified the claimant that her claim for carpal tunnel syndrome was denied. 303 Or at 52-53.

Johnson began its analysis by noting that the *Bauman* rule "applies only to a claim 'specifically' or 'officially' accepted by the insurer." 303 Or at 55. Acceptance and denial is governed by ORS 656.262(6), which provides in relevant part:

> "Written notice of acceptance or denial of the claim shall be furnished to the claimant by the insurer or self-insured employer within 60 days after the employer has notice or knowledge of the claim.* * *"

When the notice of acceptance issued pursuant to ORS 656.262(6) is silent regarding a condition or injury which is part of a single claim, this silence cannot be construed as acceptance of the condition, because "[i]f an insurer specifically accepts in writing only one of several conditions or injuries encompassed by a single claim, the insurer has not 'specifically' or 'officially' accepted the other conditions allegedly related to the accepted part of the claim." 303 Or at 56. The scope of the insurer's acceptance in *Johnson* was limited to the back injury because the carpal tunnel syndrome was a separate condition not specified in the acceptance notice. *Id.*

After concluding that the insurer's silence did not constitute acceptance of the carpal tunnel syndrome, the opinion examined the validity of the insurer's partial denial. In upholding the partial denial,[4] we stated that a partial denial is appropriate if the insurer specifies which conditions it accepts and which it denies, and "that specificity, which promotes timely closure of accepted conditions and prompt appeals of denied conditions, is the essence of a partial denial." *Id.*

Relying on *Johnson*, the Court of Appeals held that

[4] Because the insurer's denial came more that 60 days after the claim, the court recognized that the insurer may be subject to a penalty pursuant to ORS 656.262(10). *Johnson v. Spectra Physics*, 303 Or 49, 58-59, 733 P2d 1367 (1987).

Georgia-Pacific's acceptance of the claim for a "sore back" did not cover the ankylosing spondylitis condition and Georgia-Pacific could subsequently deny the compensability of the condition. Apparently the court reasoned that accepting a claim for a sore back was not sufficiently specific to constitute acceptance of the compensability of the ankylosing spondylitis. *Georgia-Pacific v. Piwowar, supra,* 86 Or App at 85.[5] Contrary to the Court of Appeals reading of *Johnson,* acceptance need not meet any degree of specificity. The case holds

only that the scope of acceptance corresponds to the condition specified in the acceptance notice, which was a "back injury" in that case. Here we face the question of whether an acceptance of a claim for a condition includes acceptance of the compensability of the disease causing that condition.

Bauman holds that once an insurer accepts a claim, it must compensate for that claim. Whether the claim in fact arose from a noncompensable cause is irrelevant. 295 Or at 794. *Johnson* upholds a partial denial made after an acceptance where a single claim encompasses two *separate conditions.* That decision rests on the acceptance of a claim for a condition or injury; that is, acceptance of the compensability of symptoms, not the medical cause of those symptoms, because in *Johnson,* the court recognized that the two separate injuries arose from the same work-related cause. 303 Or at 56-57.

Read together, *Johnson* and *Bauman* require the employer to compensate the claimant for the specific condition in the notice of acceptance regardless of the cause of that condition. If, for example, Georgia-Pacific accepted a claim for "lumbosacral strain," which was one of the original diagnoses of claimant's condition, that acceptance would not include the ankylosing spondylitis, since those are two separate infirmities (unless of course one is merely a symptom of the other). Under the logic of the Court of Appeals' rule that "unless the specific condition is part of the accepted claim, denial of a specific condition is not precluded by *Bauman*[,]" an insurer could avoid the *Bauman* rule and litigate compensability in any case in which the accepted condition may be attributed to a more specific cause.

Allowing an insurer to deny compensation for a previously-accepted condition once it learns that the condition is attributable to a specific noncompensable disease opens the door to instability, uncertainty and delay. This is precisely the kind of vacillation which this court found unacceptable in *Bauman,* 295 Or at 793-794.

Here, Georgia-Pacific accepted a claim for a sore back, which was merely a symptom of an underlying disease, not a separate condition. Therefore, Georgia-Pacific could not deny the compensability of the condition regardless of the cause. Accordingly, we hold that Georgia-Pacific could not

properly deny the compensability of the ankylosing spondylitis. Because the denial was invalid, ORS 656.262(2) is not

[5] "Although acceptance of a 'sore back' claim could be read as acceptance of any condition causing the soreness, under *Johnson,* as we understand it, unless the specific condition is part of the accepted claim, denial of a specific condition is not precluded by *Bauman.*" *Georgia-Pacific v. Piwowar,* 86 Or App 82, 85, 738 P2d 225 (1987).

authority for suspending the payments ordered in the determination order.

Georgia-Pacific also relies on ORS 656.313 as authority for terminating compensation payments awarded in a determination order pending a hearing on the order. ORS 656.313 provides in relevant part:

> "(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 [death and permanent total disability], 656.210 [temporary total disability] and 656.214 [permanent partial disability] and does not include the payment of medical services."

Adopting language in the first order of the Workers' Compensation Board, Georgia-Pacific asserts that "no statute requires that an award made by the Evaluation Division in a Determination Order be paid pending a requested hearing on that Determination Order." Georgia-Pacific claims that because ORS 656.313 provides that requests for "review or court appeal" shall not stay payments of compensation, the legislature intended to exclude hearings regarding determination orders from proceedings for which payments are not stayed, since hearings are not reviews or court appeals. To support its argument that the legislature intended to make such a distinction, Georgia-Pacific compares the *ex parte* nature of proceedings in the Evaluations Division and the inexperience of Evaluations Division officials to the litigation setting of a hearing or Board review.[6]

We find this argument untenable for two reasons. First, ORS 656.262(4) provides:

> "The first instalment of compensation shall be paid no later than the 14th day after the subject employer has notice or knowledge of the claim. *Thereafter, compensation shall be paid at least once each two weeks,* except where the director determines that payment in instalments should be made at some other interval.* * *" (Emphasis added.)

OAR 436-60-150(5)(a) provides in relevant part:

> "Timely payment of permanent disability benefit has been made when paid no later than the 30th day after:
>
> "(a) Date of determination order by the Workers' Compensation Department[.]* * *"

These provisions, read in combination with ORS 656.262(2), previously quoted, provide for continuous compensation pay-

[6] Georgia-Pacific's characterization of determination orders as the product of an *ex parte* proceeding rendered by administrators who are not familiar with the law tends to assume facts which are not of record.

ments, ceasing only when the claim is denied or an order modifies or extinguishes the duty to pay. *See Georgia-Pacific v. Hughes, supra,* 305 Or at 293. This interpretation necessarily requires that compensation awarded in a determination order be paid pending a hearing on the extent of disability.

The second reason for rejecting the conclusions of the Board, as adopted by Georgia-Pacific, is found in *SAIF v. Maddox,* 295 Or 448, 667 P2d 529 (1983). *Maddox* addresses whether the Evaluations Division has jurisdiction to determine the extent of a claimant's disability before the issue of compensability is determined on appeal. *Former* ORS 656.313[7] was controlling. *Maddox* holds that

> [ORS 656.313(4)] clarifies the intent of the legislature to include within the 'compensation' that shall not be stayed under subsection (1) *awards determining the extent of disability.* By providing that *payment of disability in any degree shall not be stayed,* the legislature must have necessarily intended that a determination of extent of disability would not be stayed pending an appeal of compensability, for that

> would effectively defeat the purpose of subsection (1)." 295 Or at 454 (emphasis added).[8]

A determination order is clearly an "award determining the extent of disability." *Maddox* did not limit its holding to cases in which the insurer appeals, nor is the quoted language limited to awards pending Board review or court appeal. Implicit in this reasoning is the conclusion that payments awarded in a determination order must continue until a referee or appellate body orders otherwise.

According to Georgia-Pacific, interpreting the workers' compensation statutes in a manner which forbids the insurer from denying the compensability of a condition then withholding compensation for that condition leads to an absurd result when, as in this case, new evidence indicates that the disabling condition is not compensable. The claimant's hearing request extinguished the jurisdiction of the Evaluations Division to reconsider its decision. ORS 656.268(4). Georgia-Pacific claims that without reconsideration, the insurer is left with no effective procedure for contesting compensability. However, compensability was no longer an issue when the claim was turned over to the Evaluations Division, because Georgia-Pacific had already accepted the claim. *Bauman v. SAIF, supra,* 295 Or at 794. If Georgia-Pacific wished to contest other aspects of the determination order, it could request a hearing. ORS 656.283(1).

---

[7] At the time, ORS 656.313(1) provided: "Filing by an employer or the State Accident Insurance Fund Corporation of a request for review or court appeal shall not stay payment of compensation to a claimant."

[8] Part of the *Maddox* holding was overruled in *Southwest Forest Industries v. Anders,* 299 Or 205, 701 P2d 432 (1985). *Maddox* held that ORS chapter 19 never applies to appeals of Workers' Compensation Board decisions, and therefore ORS 656.313 alone governs appellate procedure. *SAIF v. Maddox,* 295 Or 448, 452-453, 667 P2d 529 (1983). *Anders* held that chapter 19 may apply to appeals from administrative decisions. 299 Or at 210-211. Even though the first step in the *Maddox* analysis was overruled in *Anders,* the *Maddox* interpretation of ORS 656.313 is still viable precedent because *Anders* held only that the statement in *Maddox* that chapter 19 never applies was too broad. 295 Or at 210. *Anders* did not hold that *Maddox* improperly rejected applying chapter 19 in favor of applying ORS 656.313, and therefore interpreting ORS 656.313 was a necessary part of the *Maddox* holding.

The crux of Georgia-Pacific's argument is that unless it may suspend payments prior to a hearing, it will be forced to pay the entire award before a hearing is held even if it pays the award in installments as authorized in ORS 656.216(1). Any result which precludes effective review of determination orders, it argues, is ridiculous.

We are not persuaded that such a result indicates that the legislature contemplated a procedure other than paying the award of the determination order pending a hearing. The 1987 legislature amended the hearings provision to require that hearings be held within 90 days of a request, ORS 656.283(4) (*amended by* Or Laws 1987, ch 884, § 11), which indicates the legislature's recognition that following proper procedures may have resulted in delayed hearings.

Contrary to the argument of Georgia-Pacific, neither ORS 656.262(2) nor ORS 656.313 authorized Georgia-Pacific to terminate payments of compensation awarded in the determination order. Because Georgia-Pacific offers no other authority for terminating payments, we hold that it was required to continue paying as ordered.

II. PENALTIES AND ATTORNEY FEES

Two separate hearings were held in this case. One addressed the determination order and another addressed Georgia-Pacific's refusal to obey the order in the first hearing. Each hearing resulted in an independent award of penalties and attorney fees.

Penalties are authorized in ORS 656.262(10), which provides:

> "If the insurer or self-insured employer unreasonably delays or unreasonably refuses to pay compensation, or unreasonably delays acceptance or denial of a claim, the insurer or self-insured employer shall be liable for an additional amount up to 25 percent of the amounts then due plus any attorney fees which may be assessed under ORS 656.382."

ORS 656.382(1) provides in relevant part:

> "If an insurer or self-insured employer refuses to pay compensation due under an order of a referee, board or court, or otherwise unreasonably resists the payment of compensation, the employer or insurer shall pay to the claimant or the attorney of the claimant a reasonable attorney fee as provided in subsection (2) of this section.* * *"

In the first hearing (WCB Case No. 82-09391), the referee penalized Georgia-Pacific for refusing to pay the amount of the determination order award which was due at the time of the hearing. Georgia-Pacific appealed this order to the Board and made no payments pending resolution of the

appeal. The Board first reversed the referee's assessment of penalties, but on reconsideration, the Board affirmed the award of penalties and attorney fees.

Piwowar requested a second hearing (WCB Case No. 83-07720) to address the issue of Georgia-Pacific's obligation to pay the amount awarded in the first hearing. The referee in

the second hearing concluded that the amount due under the first referee's order was compensation for the purposes of ORS 656.313 and therefore payments under that order were not stayed pending the appeal of that order. The second referee did not assess penalties for Georgia-Pacific's failure to pay the first referee's order. However, on review the Board awarded attorney fees and imposed a penalty based on the amount of the first referee's order less the amount of the penalty assessed by the first referee.

The Court of Appeals found that Georgia-Pacific acted unreasonably in refusing to pay in both instances, and the court upheld both awards of penalties and attorney fees. 86 Or App at 85-86.

Georgia-Pacific justifies its refusal to pay under the determination order on the grounds that it acted upon a good faith interpretation of existing law and therefore its refusal to pay the determination order award was not unreasonable. The Court of Appeals found that Georgia-Pacific acted unreasonably even after that court erroneously upheld Georgia-Pacific's denial. We conclude that the record supports the finding of the Court of Appeals.

In response to the second award of a penalty and attorney fees, Georgia-Pacific contends that the payment ordered by the first referee was not compensation for the purposes of ORS 656.313 because that referee found that the claim was not compensable. Georgia-Pacific reasons that if the award was not compensation, ORS 656.313 does not apply and payments ordered by the first referee were stayed pending appeal. Since those payments were not "then due," penalties were inappropriate, according to Georgia-Pacific.

The determination order awarded payment for a disability, which constitutes compensation under ORS 656.313(4). Regardless of the ultimate determination of compensability, the first referee ordered payment of compensation

which was not stayed pending appeal of that order. *Georgia-Pacific Corporation v. Hughes, supra*, 305 Or at 293-294. We therefore agree that penalties and attorney fees are appropriate.

The decision of the Court of Appeals is affirmed in part and reversed in part. The decision of the Workers' Compensation Board on reconsideration in WCB Case No. 82-09391 is affirmed. The decision of the Workers' Compensation Board in WCB Case No. 83-07720 is affirmed.

IN THE SUPREME COURT OF THE
STATE OF OREGON

In the Matter of the Compensation
of Martin Greenslitt, Claimant.

GREENSLITT,
Petitioner on Review,

v.

CITY OF LAKE OSWEGO et al,
Respondents on Review.

(WCB 82-00591; CA A41824; SC S34680)

In Banc

On review from the Court of Appeals.*

Argued and submitted March 2, 1988.

James L. Edmunson, Malagon & Moore, Eugene, argued the cause and filed the petition for petitioner on review. With him on the petition was Karen M. Werner, Eugene.

Darrell E. Bewley, Assistant Attorney General, Salem, argued the cause for respondents on review. With him on the response were Dave Frohnmayer, Attorney General, and Virginia L. Linder, Solicitor General, Salem.

PETERSON, C. J.

The decisions of the Court of Appeals and Workers' Compensation Board are affirmed.

---

* Judicial review of order of Workers' Compensation Board, 88 Or App 94, 744 P2d 577 (1987).

PETERSON, C. J.

The issue in this case is whether the Workers' Compensation Board, on an employer's request for board review of a compensation claim, has authority to review a referee's award of attorney fees made under ORS 656.386(1). The Court of Appeals held that the board was the proper forum for the attorney fees dispute. *Greenslitt v. City of Lake Oswego,* 88 Or App 94, 744 P2d 577 (1987). We affirm.

The claimant was employed by the City of Lake Oswego. The employer's insurer, the State Accident Insurance Fund (SAIF), denied the claimant's occupational disease claim. The claimant requested a hearing. The referee held that the claim was compensable and ordered that the claim be remanded to SAIF for acceptance. In the same order, pursuant to ORS 656.386(1), the referee ordered that the claimant's attorney be "awarded an extraordinary attorney fee of $7,000 for prevailing upon the denials, with the same to be paid by SAIF and not to be taken from the benefit due claimant."

SAIF requested board review of the referee's order. ORS 656.289(3), 656.295. The board affirmed the referee on

the merits, but reduced the referee's attorney fee award to $3,000.[1]

The claimant sought review in the Court of Appeals of the board's reduction of attorney fees, arguing that the

board was without jurisdiction to review a referee's award of attorney fees and that the proper forum for such disputes was the circuit court under ORS 656.388(2). The Court of Appeals held that "[b]ecause in this case employer sought Board review of the referee's compensability determination, the Board had jurisdiction to review the attorney fee award." 88 Or App at 100. We hold that the board had authority to review the referee's award of attorney fees and affirm.

This case involves three related statutes: ORS 656.382 (penalties and attorney fees payable by insurer in processing claim), ORS 656.386 (recovery of attorney fees in appeal on denied claim) and ORS 656.388 (circuit court review of attorney fees).

ORS 656.386 and ORS 656.388

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 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." (Emphasis added.)

At the relevent time, ORS 656.388(2) 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 for the circuit court in the county in which the claimant resides. * * *"

There are three prerequisites to the applicability of the attorney fees provision of ORS 656.386(1): (1) the claim-

[1] The board stated:

"The Referee awarded claimant's attorney a fee of $7,000 for services at hearing, noting his impression that the services rendered by claimant's attorney were 'extraordinary.' OAR 438-47-015 provides the Referee the discretion to award an attorney fee of up to $3,000 on a denied claim ordered accepted by the Referee. The Referee or Board may allow a fee in excess of the rule's maximum when claimant's attorney provides a sworn statement regarding the services rendered on claimant's behalf, and the services are deemed to have been extraordinary. OAR 438-047-010(2).

"In the present case, no sworn statement was submitted to the Referee. No showing nor request was made at hearing for an extraordinary fee. See *Roger A. Shoff*, 38 Van Natta 163, 164 (1986). Although the Referee felt that the efforts expended by claimant's attorney were 'extraordinary,' he did not acknowledge the absence of a sworn statement regarding an extraordinary fee. Without benefit of the sworn statement, the Referee had no discretion to award a fee in excess of the $3,000 maximum allowed by administrative rule. Without the sworn statement, we, too, are constrained from awarding more than the maximum allowed by our rule. Claimant's attorney's fee for services at hearing shall therefore be reduced to $3,000. * * *"

ant must initiate the hearing process by requesting review from an order or decision denying the claim; (2) the claimant must prevail *finally* on the issue of compensation (before the forum in which the claimant is the initiating party); and (3)

the decision of the referee, board or court in which the claimant prevails finally must be from an earlier decision or order denying, rather than allowing, the claim for compensation. *Shoulders v. SAIF,* 300 Or 606, 611-12, 716 P2d 751 (1986). A claimant "prevails finally" before a forum if that forum holds in the claimant's favor on the issue of the claimant's right to workers' compensation and that determination is not appealed within the time allowed by statute. For example, "[u]nder ORS 656.289(3), the matters determined by [a referee's order become] 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 review by the board under ORS 656.295.' " *Farmers Ins. Group v. SAIF,* 301 Or 612, 619, 724 P2d 799 (1986).[2]

Had the claimant in this case "prevailed finally" before the referee on the merits of his workers' compensation claim, leaving only attorney fees in dispute, the circuit court would have been the proper forum to review the referee's award of attorney fees. However, in the present case, SAIF, the employer's insurer, timely sought review of the referee's order. Because the claimant did not "prevail finally" before the referee, ORS 656.386(1) is not applicable.

In this case, and in two companion cases, *Guill v. Pendleton Woolen Mills,* 305 Or 538, ___ P2d ___ (1988) and *Short v. SAIF,* 305 Or 541, ___ P2d ___ (1988), the referees' orders concerning attorney fees were in the orders concerning the merits of the case. We do not dispute the efficiency of that practice. But we must recognize that ORS 656.386 does not

authorize a referee to "allow a reasonable attorney fee" until the claimant "prevails finally" on the merits. ("[W]here the claimant prevails finally * * *, *then* the referee or board shall allow a reasonable attorney fee.") (emphasis added.) If the referee issues such an order before the claimant prevails

[2] The claimant relies on the following passage from *Farmers Ins. Group* to support his argument that he is entitled to circuit court review of the board's determination concerning attorney fees:

> "[A]ny 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 it to be resolved under the unique provisions of ORS 656.388(2)."

301 Or at 619. In *Farmers Ins. Group,* this court held that the referee's order relating to compensation became final thirty days after its issuance even though the referee had yet to decide the issue of attorney fees at the time of the compensation order. In context, the quoted statement referred to the court's holding that despite the fact that attorney fees had not yet been awarded, the time for appeal to the board was not extended because determination of attorney fees was not necessary to the determination of compensability and that *once the referee's order became final* (*i.e.* once the claimant "prevailed finally" before the referee), the appropriate forum for review of attorney fees was the circuit court.

finally, it is interlocutory in nature unless and until the 30-day appeal period runs.[3] If the merits are appealed, the attorney fees issue becomes part of the appeal and the board has authority to determine a proper fee for legal representation before it as well as a proper fee for representation before the referee. Should the claimant successfully defend against the employer's insurer's appeal, as in this case, attorney fees are awarded under ORS 656.382, discussed below.

ORS 656.382

ORS 656.382(2) provides for attorney fees to a claimant in an employer-initiated review or appeal where compensation is not reduced or disallowed. *See Shoulders v. SAIF, supra,* 300 Or at 615; *Bracke v. Baza'r,* 294 Or 483, 490, 658 P2d 1158 (1983). Otherwise stated, a "claimant is entitled to reasonable attorney fees [under this section] for successfully defending against reduction of compensation." *Shoulders,* 300 Or at 610. Unlike ORS 656.386(1), ORS 656.382(2) makes no reference to ORS 656.388(2). ORS 656.382(2) provides:

> "If a request for hearing, request for review, appeal or cross-appeal to the Court of Appeals or petition for review to the Supreme Court is initiated by an employer or insurer, and the referee, board or court finds that the compensation awarded to the 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 court for legal representation by an attorney for the claimant at and prior to the hearing, review on appeal or cross-appeal."

This section does not provide for circuit court review

via ORS 656.388(2). It does provide that the forum to which the employer has appealed may review the fees for "legal representation by an attorney for the claimant at and *prior to* the [present] hearing, review on appeal or cross appeal." (Emphasis added.)[4] That is this case. Because the claimant did not "prevail finally" before the referee on the issue of compensability (as a result of SAIF's timely request for board review), the appropriate forum to review the referee's order concerning both the compensation issue and the attorney fees issue was the board rather than the circuit court. The statutes do not contemplate inefficient use of resources in which the merits of the dispute and the issue of attorney fees are reviewable by different forums at the same time.

The legislative history supports the conclusions expressed above. See discussion in *Shoulders v. SAIF, supra,* 300 Or at 613-15.

[3] In this connection, we note that *SAIF v. Culwell,* 65 Or App 332, 671 P2d 759 (1983), *rev den* 296 Or 411 (1984), suggests that a claimant has only 30 days from the date of a referee's or the board's order *on the merits* to seek circuit court review of the award of attorney fees made by the referee or board. Although we do not decide today the appropriate time limitation, it is arguable that within 30 days after the referee's or board's order *on attorney fees becomes effective* may be an appropriate limitation as it is consistent with other time limitation provisions of the Workers' Compensation Law.

[4] We agree with the Court of Appeals opinion herein that

> "[w]hen 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 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."

88 Or App at 99 n 6 (emphasis by Court of Appeals); *see also Hubble v. SAIF,* 57 Or App 513, 647 P2d 474, *rev den* 293 Or 521 (1982).

The claimant argues that if this court concludes that the board has jurisdiction over the referee's determination of appropriate attorney fees in the event of a timely request for board review by the employer or insurer, employers and insurers will be encouraged to "appeal the compensability decision, and thereby invoke the board's jurisdiction in the fee dispute regardless of the independent nature of the fee dispute."[5] This concern was not overlooked by the legislature. In fact this concern was the motivation behind what was to become ORS 656.382(2). As stated by Justice Lent in a comprehensive review of the history of Workers' Compensation Law:

> "During the testimony before legislative committees considering the 1965 revision [of Workers' Compensation Law], opponents of HB 1001 (the vehicle for revision) expressed fear that the adversarial position of the employer or SCD [the State Compensation Department, SAIF's predecessor], on the one hand, and the claimant, on the other, might result in the former pursuing appeals at each level for the purpose of wearing down or harassing claimants. The answer was to provide that where the employer or SCD initiated 'a request for hearing, request for review or court appeal' and the claimant successfully defended his award, the employer or SCD, as the case might be, would become liable for reasonable attorney fees in addition to the award of benefits. Or Laws 1965, ch 285, § 42(2). That section become ORS 656.382(2) * * *."

Bracke v. Baza'r, supra, 294 Or at 487 (footnote omitted). Of particular importance is the fact that should an employer or an insurer seek review before the board, it is potentially liable for additional attorney fees for the claimant's representation before that forum. In contrast, should the employer or insurer simply seek review of attorney fees before the circuit court, it does not expose itself to additional liability for attorney fees.[6]

Because the claimant did not prevail finally before the referee, ORS 656.386(1) providing for circuit court resolution of attorney fees disputes does not apply. The decisions of the Court of Appeals and Workers' Compensation Board are affirmed.[7]

[5] In *Wattenbarger v. Boise Cascade Corp.*, 301 Or 12, 15, 717 P2d 1175 (1986), this court held a board rule issued under ORS 656.388 (1985) to "establish a suggested schedule of fees" was not binding on a circuit court. Despite the fact that different standards would apply depending on the forum in which the attorney fee issue was heard, we stated that "[a] 'suggested schedule' implies that the addressee is expected to exercise some judgment. It is not a term legislators would use if they meant a Board rule to be legally binding on a court that is empowered, in the same section, to reexamine the fee." *Id.* (footnote omitted). In 1987 the legislature deleted the term "suggested" from ORS 656.388. Or Laws 1987, ch 884, § 35(4).

[6] Interestingly, the Workers' Compensation Law provides for penalties (in addition to attorney fees) "[i]f upon reaching a decision on a request for a hearing it is found *by the referee* that the employer initiated the hearing for the purpose of delay or other vexatious reason or without reasonable ground," ORS 656.382(3) (emphasis added), or if either party appeals to an appellate court and the appellate court finds that the appeal "was frivolous or was filed in bad faith or for the purpose of harassment," ORS 656.390. However, there are no statutory provisions for the board to sanction a party in this manner. Of course, the determination of whether the board should have such power is one for the legislature. *See* ORS 174.010.

[7] The continued existence of ORS 656.388(2) and the next to last sentence of ORS 656.386(1) (fee disputes "shall be settled as provided for in ORS 656.388(2)") create an anomalous situation. Although the board, the Court of Appeals and this court have authority to make decisions concerning the amount of attorney fees to be awarded under ORS 656.386(1), either the claimant or the employer or insurer can ask the circuit court to "determine the amount of such fee" "in a summary manner." The circuit court decision, in turn, could be reviewed by the Court of Appeals and this court. On such an appeal an appellate court would be reviewing the question whether a trial court erred in modifying or refusing to modify a previous decision of the very appellate court considering the appeal from the trial court. Perhaps this should be addressed by the legislature.

IN THE SUPREME COURT OF THE
STATE OF OREGON

In the Matter of the Compensation
of Margie M. Guill, Claimant.

GUILL,
Petitioner on Review,

v.

PENDLETON WOOLEN MILLS,
Respondent on Review.

(WCB 85-09065; CA A42368; SC S34681)

In Banc

On review from the Court of Appeals.*

Argued and submitted March 2, 1988.

Robert Wollheim, Welch, Bruun & Green, Portland, argued the cause and filed the petition for petitioner on review.

Mildred J. Carmack, Schwabe, Williamson & Wyatt, Portland, filed the response brief for respondent on review.

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, 88 Or App 130, 744 P2d 581 (1987).

PETERSON, C. J.

The claimant prevailed at a hearing before the Workers' Compensation Board referee in establishing the compensability of her injury claim. Her employer appealed to the board, which affirmed the referee on compensability but reduced the fee that the referee awarded the claimant's attorney. The claimant seeks review of the Court of Appeals' decision holding that the board, rather than the circuit court, had jurisdiction to review the referee's award of attorney fees.

The employer sought review of the referee's decision. As a result, the claimant did not prevail finally before the referee. The proper forum to review the referee's fee award was the board. *Greenslitt v. City of Lake Oswego, 305 Or 530,* ___, ___, ___ *P2d* ___ *(1988). See also* ORS 656.382(2), 656.386(1).

The decisions of the Court of Appeals and the Workers' Compensation Board are affirmed.

IN THE SUPREME COURT OF THE STATE OF OREGON

In the matter of the Compensation of Lee E. Short, Claimant.

SHORT,
Petitioner on Review,

v.

STATE ACCIDENT INSURANCE FUND CORPORATION et al,
Respondents on Review.

(A8606-03219; CA A41221; SC S34725)

In Banc

On review from the Court of Appeals.*

Argued and submitted March 1, 1988.

Richard A. Sly, Portland, argued the cause and filed the petition for petitioner on review.

Darrell E. Bewley, Assistant Attorney General, Salem, argued the cause for respondent on review. With him on the response were Dave Frohnmayer, Attorney General, and Virginia L. Linder, Solicitor General, Salem.

PETERSON, C. J.

The decision of the Court of Appeals is affirmed and the judgment of the circuit court is reversed.

* On appeal from Circuit Court, Multnomah County, Charles S. Crookham, Judge. 88 Or App 226, 745 P2d 422 (1987)

PETERSON, C. J.

Like its companion cases of *Greenslitt v. City of Lake Oswego,* 305 Or 530, ___ P2d ___ (1988), and *Guill v. Pendleton Woolen Mills,* 305 Or 538, ___ P2d ___ (1988), both decided this date, this case concerns the award of attorney fees in a workers' compensation case.

The claimant appeals from a Court of Appeals' decision holding that the circuit court was without authority to require the State Accident Insurance Fund (SAIF) to pay attorney fees in addition to the amount previously ordered by the Workers' Compensation Board (board) and approved by the Court of Appeals on review. *Short v. SAIF,* 88 Or App 226, 745 P2d 422 (1987) (*Short II*). We affirm the Court of Appeals.

THE FACTS

The claimant suffered a compensable injury in February 1977. Her claim was closed in July 1979 with an award for partial disability. In September 1982 she requested a reopening of her claim based upon a newly diagnosed injury. SAIF denied the request and the claimant requested a hearing. The referee ordered that the claim be reopened as of September 1982 and imposed a penalty upon SAIF for unreasonable delay in denying the claim and in paying interim compensation. The referee 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 the newly diagnosed condition was not compensable, or alternatively, that a later reopening date was appropriate. The claimant cross-appealed, seeking an earlier reopening date. The board modified the referee's order, delaying the reopening to March 1983. The board reduced the penalty and associated attorney fees, but increased the attorney fee for prevailing on the denied claim to $3,750 and awarded an additional attorney fee of $750 for representation before the board.

The claimant sought review in the Court of Appeals and assigned error to the board's order concerning the date of reopening and the amount of attorney fees awarded by the board. The Court of Appeals (1) ordered that the proper date for reopening was September 1, 1982, not March 1983, (2) ordered reinstatement of the referee's order concerning the

penalty issue, and (3) upheld the board's award of attorney fees. *Short v. SAIF,* 79 Or App 423, 719 P2d 894 (1986) (*Short I*).

The claimant then petitioned the circuit court for an increase in the board's attorney fee award. The circuit court raised the fee award to $12,000 and ordered SAIF to pay that amount minus amounts it had already paid. SAIF appealed to the Court of Appeals, arguing that the circuit court lacked jurisdiction to modify the attorney fee award. The Court of Appeals held that ORS 656.386(1) was not applicable because the claimant did not initiate *board* review and that ORS 656.382(2) "is the sole basis for an award of employer paid fees when an employer initiates the final review process. * * * That statute does not provide for circuit court review of attorney fees." *Short II,* 88 Or App at 230.

DISCUSSION

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 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."

At the relevant time, ORS 656.388(2) 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 for the circuit court in the county in which the claimant resides. * * *"[1]

We stated in *Greenslitt v. SAIF, supra:*

> "There are three prerequisites to the applicability of the attorney fees provision of ORS 656.386(1): (1) the claimant must initiate the hearing process by requesting review from an order or decision denying the claim; (2) the claimant must prevail *finally* on the issue of compensation (before the forum in which the claimant is the initiating party); and (3) the decision of the referee, board or court in which the claimant prevails finally must be from an earlier decision or order denying, rather than allowing, the claim for compensation. *Shoulders v. SAIF,* 300 Or 606, 611-12, 716 P2d 751 (1986). A claimant 'prevails finally' before a forum if that forum holds in the claimant's favor on the issue of the claimant's right to workers' compensation and that determination is not appealed within the time allowed by statute. For example, '[u]nder ORS 656.289(3), matters determined by [a referee's order become] 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 review by the board under ORS 656.295." *Farmers Ins. Group v. SAIF,* 301 Or 612, 619, 724 P2d 799 (1986).' " (Emphasis in original.)

The claimant argues that the board's award of attorney fees was reviewable by the circuit court or "[t]he attorney fees awarded by the Court of Appeals by their de novo decision * * * was * * * subject to summary review by a circuit court pursuant to 656.388(2)." The claimant is not entitled to circuit court review of the fee award of the board or the Court of Appeals. ORS 656.386(1) provides for attorney fees on review of denied claims. The claimant did not appeal to the board or to the Court of Appeals from a decision denying her claim. Both the referee and the board concluded that the claimant's condition was compensable. Where the only compensation issue on appeal is the amount of compensation or the extent of disability, rather than whether the claimant's condition was caused by an industrial injury, ORS 656.386(1) is not the applicable attorney fee statute and the ORS 656.388(2) route to the circuit court is not available. *Shoulders v. SAIF,* 300 Or

606, 615, 716 P2d 751 (1986). *See also Vandehey v. Pumilite Glass and Building Co.,* 35 Or App 187, 580 P2d 1068 (1978) (ORS 656.386 not applicable because employer conceded causation, issue was extent of treatment warranted); *Smith v. Amalgamated Sugar Co.,* 25 Or App 243, 548 P2d 1329 (1976) (extent of disability, rather than cause of injury, disputed); *Grudle v. SAIF,* 4 Or App 326, 479 P2d 250 (1971) (amount of compensation for amputation, rather than cause of injury, disputed). *Cf. Ohlig v. FMC Marine & Rail Equipment,* 291 Or 586, 633 P2d 1279 (1981) (where employer denies compensability of a condition, rather than disputes extent of liability

[1] Oregon Laws 1987, chapter 884, section 35 deleted the reference to "appellate court" in ORS 656.388(2). At oral argument the claimant expressed concern that claimants would no longer be able to seek review of appellate court fee awards as a result of that amendment. However, even after the 1987 amendments to the Workers' Compensation Law, ORS 686.386(1) still provides that "[i]n 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 686.388(2)," *i.e.* by circuit court review.

The claimant's concern perhaps results from a misunderstanding of the source of her right to circuit court review of attorney fees not paid from the claimant's award. That right results from ORS 656.386(1), not ORS 656.388(2). *See Greenslitt v. City of Lake Oswego,* 305 Or 530, ____ P2d ____ (1988).

and amount of compensation due, employer has "denied" the claim, distinguishing *Vandehey, Smith and Grudle); Cavins v. SAIF*, 272 Or 162, 536 P2d 426 (1975) (same).[2]

Where the claimant appeals the amount of liability or extent of disability, as in the present case, he or she concurrently may seek review of the attorney fee award in the forum in which the merits are presented. In such case, there is no statutory provision providing for circuit court review of that forum's determination of the appropriate attorney fee award. Where the insurer appeals the compensability of a claim or the amount or extent of liability, as the insurer did in this case before the board, the insurer is liable for attorney fees under ORS 656.382(2)[3] if the compensation awarded to the claimant is not disallowed or reduced. That statute does not provide for circuit court review.

The decision of the Court of Appeals is affirmed and the judgment of the circuit court is reversed.[4]

---

[2] The claimant also argues that "the Supreme Court in *Wattenbarger v. Boise Cascade Corp.*, [301 Or 12, 717 P2d 1175 (1986),] approved the use of the summary circuit court proceeding allowed by ORS 656.388 where, such as in the instant case, the employer initiated an appeal to the Workers' Compensation Board following a referee order wherein claimant prevailed on a denied claim." Although an exercise in fact matching may reveal similarity between this case and *Wattenbarger*, that case does not stand for approval of summary circuit court proceedings under any given facts. At issue in that case was whether the circuit court was bound by the board's "suggested schedule of fees." *See Greenslitt v. City of Lake Oswego, supra*, 305 Or at ____ n 5. Both parties assumed that the circuit court had jurisdiction.

[3] 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."

[4] The conclusion that ORS 656.386(1) is not applicable where the claimant successfully appeals for purposes of gaining an increase in compensation is bolstered by the legislative history of 1983 proposed amendments to ORS 656.386 and ORS 656.388 (Senate Bill 589). The legislature considered and rejected a proposal to grant attorney fees in such an instance. One of the "problems" that the Senate Committee on Labor was asked to address was summarized in this manner:

> "Claimant is awarded permanent partial disability (not 'denied' or 'rejected') but increases benefits after hearing, board review or court review (or stipulation). No provision for claimant's attorney fees payable by employer or insurer."

Senate Committee on Labor, Ex D to SB 589 (May 20, 1983).

The original version of SB 589, which sought to amend ORS 656.386, proposed the following response to this "problem":

> "When claimant is awarded an increase in the extent of permanent disability by a referee, board, or court, the referee, board, or court shall award to claimant or claimant's attorney a reasonable attorney fee, subject to the requirements of ORS 656.388. Attorney fees provided for in this section shall be paid by the insurer or self-insured employer."

See Senate Committee on Labor, Ex D to SB 589 (May 20, 1983).

This provision did not survive the first hearing and work session of the Senate committee. *See* Minutes, Senate Committee on Labor 6-7 (May 20, 1983) (referred to as amendment "5"). The legislative history also shows that there was a House Bill on this point, *see* Minutes, Senate Committee on Labor 5 (May 20, 1983) (testimony of Representative Hanlon), which did not get out of committee.

IN THE SUPREME COURT OF THE
STATE OF OREGON

NICHOLSON,
Petitioner on Review,
v.
BLACHLY et al,
Respondents on Review,
PACIFIC FRUIT EXPRESS COMPANY,
Respondent.
(TC A8511-07449; CA A40516; SC S34421)

In Banc

On review from the Court of Appeals.*

Argued and submitted December 1, 1987.

James L. Edmunson, Eugene, argued the cause and filed the petition for petitioner on review. On the petition was Peter O. Hansen, Portland.

Allan M. Muir, Portland, argued the cause and filed the response for respondents on review. With him on the response was Schwabe, Williamson & Wyatt, Allan M. Muir, Wayne A. Williamson and Dennis S. Reese, Portland.

Dave Frohnmayer, Attorney General, Salem, filed a Brief of *Amicus Curiae* for Workers' Compensation Department. With him on the brief were Virginia L. Linder, Solicitor General, and Christine Chute, Assistant Attorney General, Salem.

CAMPBELL, J.

The decision of the Court of Appeals is affirmed in part and reversed in part. The decision of the trial court is affirmed in part and reversed in part. The case is remanded to the circuit court for further proceedings.

---

* Appeal from the Circuit Court of Multnomah County, Charles S. Crookham, Judge. 86 Or App 645, 740 P2d 220 (1987)

CAMPBELL, J.

The issue presented in this case is whether a vocational rehabilitation organization which contracts with a self-insured employer to provide assistance to an injured worker can be sued in circuit court on contract and tort claims relating to the vocational rehabilitation assistance or whether claims of inadequate assistance are in the exclusive jurisdiction of the Workers' Compensation Department[1] and Board.

---

[1] The 1987 legislature abolished the Workers' Compensation Department. Its functions are now performed by the Department of Insurance and Finance. The Workers' Compensation Board still exists and the procedures and substance of the Workers' Compensation Act remain unchanged. References to the "department" in this opinion apply equally to the Workers' Compensation Department and to the Department of Insurance and Finance in its administration of the Workers' Compensation Act. The department does include the board.

Contrary to the Court of Appeals, we hold that the department and board do not have exclusive jurisdiction over all claims against the vocational rehabilitation organization and its employes. The circuit court's dismissal of the complaint as to defendants Blachly and International Rehabilitation Associates, Inc. (IRA) is reversed. The dismissal of the complaint as to defendant Pacific Fruit Express Company (PFE) is affirmed. The decision of the Court of Appeals is affirmed in part and reversed in part.

Plaintiff filed a complaint claiming contract and tort damages from his employer together with a vocational rehabilitation organization and an employe of that organization. The case was dismissed following an ORCP 21 motion and we therefore must accept the allegations in the complaint as facts. Plaintiff has abandoned his claim against his employer in his petition for review to this court.

According to the complaint, plaintiff was employed by PFE and was injured on the job in August 1981. In November 1983, PFE, a self-insured employer, contracted with IRA to provide vocational rehabilitation assistance to plaintiff. Blachly is an employe of IRA and had direct contact with plaintiff. Plaintiff alleged that the contract provided that IRA would provide vocational rehabilitation or assistance "which would have reasonably qualified him to obtain employment at or near the wage he was earning at the time of his industrial injury (8/6/81), which was $86.24 a day or $11.00 per hour." IRA arranged employment for plaintiff as a chemical dependency counselor in Minneapolis.

Plaintiff further alleged that "the parties" signed a written agreement in March 1984 that plaintiff would be paid $11.20 an hour to perform the chemical dependency counselor job. Alternatively, plaintiff alleged that oral modifications of the March contract provide for payment at a rate of $11.00 an hour. The chemical dependency counselor job pays $7.00 an hour.

Plaintiff claimed that defendants had breached the November contract by failing to provide the vocational rehabilitation assistance as provided by the contract, and that plaintiff was an intended beneficiary of the contract. Plaintiff also claimed that the March agreement was a contract that was breached by the failure to provide payment at the rate of $11.00 an hour. Plaintiff further claimed that defendants were negligent in failing to provide adequate training or assistance, in misrepresenting the hourly wage of the Minnesota job and in failing to advise plaintiff of the consequences of accepting the Minnesota job.

All defendants moved to dismiss all claims on the grounds that the Workers' Compensation Board had exclusive jurisdiction over the claims and that the complaint failed to state a claim. The circuit court granted the motions. The Court of Appeals affirmed. *Nicholson v. Blachly,* 86 Or App 645, 740 P2d 220 (1987). Because plaintiff has abandoned his claims against PFE, we do not consider those claims and the dismissal of PFE is affirmed.

The exclusive remedy of injured employes against their employers for injuries suffered in the course and scope of

employment is to receive workers' compensation benefits. ORS 656.018(1)(a) and (2).[2] The exemption from liability

given an employer extends to the employer's insurer, the department and the employes, officers and directors of the employer, insurer and the department. ORS 656.018(3).[3] The statute does not mention any other person or entity nor does it contain language that suggests that anyone else might be protected by the exclusion of other remedies. ORS 656.154 provides that third parties may be liable outside the workers' compensation system, and this court has held that tort remedies are available to workers' compensation claimants who are negligently injured by physicians who treat their compensable injuries. *Wimer v. Miller,* 235 Or 25, 383 P2d 1005 (1963). We therefore conclude that ORS 656.018 does not make workers' compensation the only remedy available to an employe for claims against a vocational rehabilitation organization that contracts with an employer or insurer to provide assistance under the Workers' Compensation Act. Similarly, the employes of such an organization are not protected from other liability by ORS 656.018.

As there is a specific exclusion of liability for employers, insurers, the department and their respective employes, and no language in the statute suggests that the liability of others is to be limited, we cannot assume that the legislature intended any grant of jurisdiction in the act to be exclusive as to other parties. The other grants of jurisdiction in the act are stated in permissive, not exclusive terms[4] and the act in effect at the time of plaintiff's injury was not comprehensive as regards the provision of vocational rehabilitation assistance.[5] Even under the current version of the act and related regulations, the scope of a hearing on the subject of vocational rehabilitation is limited, and no remedy for contract breach or

negligence is provided. If the department has no jurisdiction to consider certain issues, it cannot have exclusive jurisdiction over those issues.

---

[2] ORS 656.018(1)(a) and (2) at the time of plaintiff's compensable injury provided:

"(1)(a) The liability of every employer who satisfies the duty required by ORS 656.017(1) is exclusive and in place of all other liability arising out of compensable injuries to his subject workers, the workers' beneficiaries and anyone otherwise entitled to recover damages from the employer on account of such injuries or claims resulting therefrom, specifically including claims for contribution or indemnity asserted by third persons from whom damages are sought on account of such injuries, except as specifically provided otherwise in ORS 656.001 to 656.794.

"* * * * *

"(2) The rights given to a subject worker and his beneficiaries for compensable injuries under ORS 656.001 to 656.794 are in lieu of any remedies they might otherwise have for such injuries against the worker's employer under ORS 654.305 to 654.335 or other laws, common law or statute, except to the extent the worker is expressly given the right under ORS 656.001 to 656.794 to bring suit against his employer for an injury."

[3] ORS 656.018(3) provides:

"The exemption from liability given an employer under this section is also extended to the employer's insurer, the department, and the employes, officers and directors of the employer, the employer's insurer and the department * * *."

[4] *See, e.g.,* ORS 656.283.

[5] Contrary to statements in the briefs and in the Court of Appeals' opinion, ORS 656.340 did not become effective until July 1, 1984, almost three years after plaintiff's compensable injury and after both contracts were entered into. *See* Or Laws 1981, ch 535, §§ 2 and 26(2).

The act does give the department and its constituent bodies jurisdiction to consider certain claims regarding the provision of vocational rehabilitation assistance. *See* ORS 656.283, 656.704(1) and 656.708. Although this jurisdiction is not necessarily exclusive, issues of primary jurisdiction may arise under some circumstances. *See Tracy v. Lane County*, 305 Or 378, ___ P2d ___ (1988). However, if some of the issues need to be first decided by the department, a question not now before us, the circuit court nonetheless has jurisdiction and should not have dismissed the complaint for lack of jurisdiction.

The parties have not addressed the issue whether the complaint states a claim. The allegations are sufficient to withstand a motion to dismiss for failure to state a claim.

The circuit court's dismissal of the complaint as to defendant Blachly and IRA is reversed. The circuit court's dismissal of the claim against PFE is affirmed. The decision of the Court of Appeals is affirmed in part and reversed in part. The case is remanded to the circuit court for further proceedings.

IN THE SUPREME COURT OF THE STATE OF OREGON

In the Matter of the Compensation of
Russell Miller, Claimant.

WEYERHAEUSER COMPANY,
Respondent on Review,

v.

MILLER,
Respondent on Review,

WORKERS' COMPENSATION BOARD,
Intervenor/Petitioner on Review.

(WCB 84-13597; CA A39349; SC S34840)

In Banc

On review from the Court of Appeals.*

Argued and submitted April 5, 1988.

Margaret E. Rabin, Assistant Attorney General, Salem, appeared on behalf of Intervenor/Petitioner on Review, Workers' Compensation Board. With her on the briefs were Virginia L. Linder, Solicitor General, and Dave Frohnmayer, Attorney General.

Paul J. DeMuniz, of Garrett, Seideman, Hemann, Robertson & De Muniz, P.C., Salem, appeared on behalf of Respondent on Review Weyerhaeuser Company.

James L. Edmunson, of Malagon & Moore, Eugene, appeared on behalf of Respondent on Review Russell Miller.

PER CURIAM

The decision of the Court of Appeals is reversed, and the order of the Workers' Compensation Board is reinstated.

Gillette, J., dissented and filed an opinion in which Lent, J., joined.

* Appeal from final order of the Workers' Compensation Board. 88 Or App 286, 745 P2d 429 (1987).

PER CURIAM

Claimant's employer in this case and claimant in *Dunn v. SAIF,* also decided today, appealed the Workers' Compensation Board's dismissal of requests for review of referees' orders, which each claimed had been timely mailed to the Board in compliance with ORS 656.295(2). That section provides:

> "The requests for review shall be mailed to the board and copies of the request shall be mailed to all parties to the proceeding before the referee."

The Board invoked its rule, OAR 438-05-040(4)(b), which stated that "filing" means

> "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."

The Board's order in each case declared that the request for review was not received by the Board. In the present case, the order stated:

> "The employer in this case has not come forward with proof of mailing as required by OAR 438-05-040(4)(b). We, therefore, conclude that timely mailing of a request for review has not been established and that we are without jurisdiction to review the Referee's order."

The order in *Dunn* stated a similar conclusion.

The Court of Appeals reversed both orders. In an opinion in this case, the majority, over a dissent, held that the Board rule exceeded the scope of its rulemaking authority. *Weyerhaeuser Company v. Miller,* 88 Or App 286, 745 P2d 429 (1987).

It is undisputed that the governing statutes require only timely mailing of a request for review. When the legislature wishes to prescribe a particular form of mailing, it says so. *See, e.g.,* ORS 19.028, 87.018, 656.298(3), 656.440(2), 656.560(2), 656.583(1). The Board rule also does not require any particular form of mailing. The Board does not refuse to treat requests for review that it receives through the mails before the deadline as properly mailed. Its rule applies only in two situations that give rise to disputes over timely mailing:

when the Board does not receive a request (or other document) alleged to have been mailed, and when the request arrives in the mail after the 30-day deadline. In such a situation, the Board's rule demands that the alleged timely mailing be demonstrated by "proof" in the form of a post office receipt "showing the date mailed and the certified or registered number."

This requirement does not exceed the scope of the Board's authority to regulate its own procedures. Agencies generally may make rules for the conduct of their own procedures even without explicit statutory authorization, *see* ORS 183.341 and 1 Cooper, State Administrative Law 176 (1965), and there is explicit authority here. The relevant sentence of ORS 656.726(4) provides:

"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."

The disputed rule does not affect evidence concerning the merits of a claim. It does not deny or disavow the Board's jurisdiction based on mailing of a request for review. It is designed only to avoid needless and wasteful controversies and evidentiary hearings over the alleged mailing dates of documents by prescribing means for proving mailing which any party can meet. The rule does not contravene statutory provisions.

Employer in this case argues that the rule only defines "filing," and ORS 656.295(2) does not refer to "filing" with regard to requests for review. The statutes and rules involved indeed are not models of consistent terminology, but we see no claim that the wording misled a party. ORS 656.313(1), a few sections after ORS 656.295(2), begins with the words "Filing by an employer or the insurer of a request for review * * *." OAR 438-11-005 provides:

"(1) The time and manner of filing for Board review is found in ORS 656.289 and 656.295.

"(2) The thirty days of ORS 656.289(3) is satisfied upon *mailing* the request to the Board."

(Emphasis supplied.) If the Board chooses to use the word

"filing" to describe how a party submits a request for review or other document to the Board, and then provides (in the regulation at issue here) that one who relies on the date of mailing as the date of filing must have specified proof in case of dispute, nothing in the statute seems to stand in the way.

The decision of the Court of Appeals is reversed, and the order of the Workers' Compensation Board is reinstated.

GILLETTE, J., dissenting.

This case presents an easy question which the majority unaccountably makes difficult. The question is: Does the Workers' Compensation Board (the Board) have the statutory authority to promulgate an administrative rule that limits the way in which a party can prove a fact material to the Board's jurisdiction to one form of proof, to the exclusion of all other forms? Because I would hold that the answer to this question is no, I am compelled to dissent from the majority's answer to the contrary.

The facts are adequately stated in the majority opinion. The Board's statutory authority to promulgate rules is found in ORS 656.726(4), which provides:

"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 * * *."

Nothing in this specific language appears to me to authorize the Board to deny to any party to a proceeding the right to offer probative evidence with respect to any issue in dispute. I have no doubt, for example, that this court would invalidate

unhesitatingly any Board rule that purported to restrict a claimant to testimony from a particular form of medical specialist, although other kinds of specialists would be able to provide probative information with respect to the medical question involved. The fact that the issue in this case is when a letter was mailed, rather than how an arm came to be broken, should not — and, to me, does not — make any difference.

When the legislature wishes to do so, it is capable of prescribing exactly how mailing is to be accomplished. *See,*

e.g., ORS 19.028[1] and 87.018.[2] Instead, it has in this case authorized mailing in plain, generic terms:

"* * * * *

"(2) The requests for review [by the Board of referees' orders] shall be *mailed* to the board and copies of the request shall be *mailed* to all parties to the proceedings before the referee."

ORS 656.295(2) (emphasis supplied). When the legislature clearly is willing to have requests for review filed in any way that constitutes a "mailing," the Board exceeds its authority when it purports without statutory authorization to narrow the ways in which that task can be accomplished. We should say so.

Neither is it a justification to say that, rather than limiting the way in which mailing can occur, the rule is merely one of proof. As I have already indicated, permitting such a rule of proof withstands scrutiny only until the potential scope of such authority is examined. And, in any event, a rule that only permits *proof* of mailing in one way is a rule that, as a practical matter, only permits *mailing* in one way.

The majority's decision today grants to the Board

authority the legislature has not given it. In the process, it undermines the salutary administrative law principle that it is the legislature, not the agency, that controls an agency's authority. The Court of Appeals majority correctly analyzed this case. It should be affirmed.

I respectfully dissent.

Lent, J., joins in this dissenting opinion.

[1] ORS 19.028 states:

"(1) Filing a notice of appeal in the Court of Appeals or the Supreme Court may be accomplished by mail. The date of filing such notice shall be the date of mailing, provided it is mailed by registered or certified mail and the party filing the notice has proof from the post office of such mailing date. Proof of mailing shall be certified by the party filing the notice and filed thereafter with the court to which the appeal is taken. If the notice is received by the court on or before the date by which such notice is required to be filed, the party filing the notice is not required to file proof of mailing.

"(2) Service of notice of appeal on a party, court reporter or the clerk of the trial court, or service of a petition for judicial review on a party or administrative agency may be accomplished by mail, subject to the same requirements as filing notice of appeal by mail as provided in subsection (1) of this section.

"(3) Except as otherwise provided by law, the provisions of subsections (1) and (2) of this section are applicable to petitions for judicial review, cross petitions for judicial review and petitions under the original jurisdiction of the Supreme Court or Court of Appeals."

[2] ORS 87.018 states:

"All notices required under ORS 87.001 and 87.060 and 87.075 to 87.093 shall be in writing and delivered in person or delivered by registered or certified mail except for the 'Information Notice to Owner' described in ORS 87.093 which may also be proved by a United States Postal Service certificate of mailing."

IN THE SUPREME COURT OF THE
STATE OF OREGON

In the Matter of the Compensation of
Sharon M. Dunn, Claimant.

DUNN,
Respondent on Review,

v.

SAIF CORPORATION et al,
Petitioners on Review,

WORKERS' COMPENSATION BOARD,
Intervenor/Petitioner on Review.

(WCB 84-13386; CA A39337; SC S34836)

In Banc

On review from the Court of Appeals.*

Argued and submitted April 5, 1988.

Margaret E. Rabin, Assistant Attorney General, Salem, appeared on behalf of Intervenor and Petitioner on Review Workers' Compensation Board and Petitioners on Review SAIF Corporation and JJ's Beauty Salon. With her on the briefs were Virginia L. Linder, Solicitor General, and Dave Frohnmayer, Attorney General.

Terrance C. Hunt, of Tamblyn & Bush, Portland, appeared on behalf of Respondent on Review. With him on the brief was Brendan Stocklin-Enright of Tamblyn & Bush, Portland.

PER CURIAM

The decision of the Court of Appeals is reversed, and the order of the Workers' Compensation Board is reinstated.

Gillette, J., dissented and filed an opinion in which Lent, J., joined.

---

* Appeal from final order of the Workers' Compensation Board. 88 Or App 291, 745 P2d 431 (1987).

PER CURIAM

The decision of the Court of Appeals in *Dunn v. SAIF*, 88 Or App 291, 745 P2d 431 (1987), is reversed. *Weyerhaeuser Company v. Miller*, 306 Or 1, ___ P2d ___ (1988). The order of the Workers' Compensation Board is reinstated.

GILLETTE, J., dissenting.

I respectfully dissent for the reasons expressed in my dissenting opinion in *Weyerhaeuser Company v. Miller*, 306 Or 1, ___ P2d ___ (1988).

Lent, J., joins in this dissenting opinion.

IN THE SUPREME COURT OF THE
STATE OF OREGON

In the Matter of the Compensation of
Pamela R. Stovall, Claimant.
STOVALL,
Respondent on Review,
v.
SALLY SALMON SEAFOOD et al,
Respondents on Review,
and
HALLMARK FISHERIES et al,
Petitioners on Review.
(WCB 84-13447, 85-01254; CA A38730; SC S33962)

In Banc

On review from the Court of Appeals.*

Argued and submitted November 5, 1987.

Paul L. Roess, Coos Bay, argued the cause and filed the petition for petitioners on review.

James L. Edmunson, Eugene, argued the cause for respondent on review Stovall. With him on the response to the petition were Karen M. Werner and Malagon & Moore, Eugene.

Craig Staples, Portland, argued the cause for respondents on review Sally Salmon Seafood and EBI Companies. On the response to the petition were Jerald P. Keene and Roberts, Reinisch & Klor, P.C., Portland.

LENT, J.

The decision of the Court of Appeals is affirmed.

Gillette, J., dissented and filed an opinion in which Peterson, C. J., and Carson, J., joined.

---

* Judicial review of order of the Workers' Compensation Board. 84 Or App 612, 735 P2d 18 (1987).

LENT, J.

The first issue is which of two successive employers is responsible for payment of workers' compensation for claimant's occupational disease, carpal tunnel syndrome. Working conditions at both employers could have caused the disease. Claimant first became disabled from the disease while working for the second employer and first sought medical treatment during that second employment. She would not have required surgery except for the second employment. We hold that the second employer is responsible.

The second issue is whether the later employer can avoid payment of compensation under the doctrine of equita-

ble estoppel because claimant falsely stated on her pre-employment application that she had never had any hand, wrist or arm trouble. We hold that the employer cannot defeat claimant's right to compensation by the defense of equitable estoppel.

I.

Since the decision in *Sahnow v. Fireman's Fund Ins. Co.*, 260 Or 564, 491 P2d 997 (1971), this court does not review the record anew to make findings of fact. We take the facts as found by the Court of Appeals as those findings may be supplemented by undisputed facts.[1] Following are the facts important to resolution of the issues in this case.

Claimant was employed at Sally Salmon Seafood (Sally) for about one year prior to June 5, 1984. She did not work every day or even all day on some days that she did work. On the other hand, she sometimes worked up to 12 hours per day and more than 40 hours in a week. Her work was shaking crab, which required her at times to strike her wrist against a pan or bench to loosen the crab meat from the shell. She also filleted fish and shucked oysters. Her work caused her to experience pain and swelling in her wrist and hand. She did not lose work on that account. She did not seek medical treatment

but alleviated her discomfort and the swelling by home treatment, utilizing a kind of liniment and ice packs. Her work with Sally ended on June 5, 1984, but not because of any disability.

On July 28, 1984, she became employed at Hallmark Fisheries (Hallmark). Prior to gaining this employment, she filled out a "PRE-EMPLOYMENT APPLICATION" on a form provided by Hallmark. On that form she checked the "No" space in answering the question: "Have you ever had—1. Hand, wrist, or arm trouble?"

Her primary work at Hallmark was as a black cod scraper. This required her several hundred times per day to scrape the blood from fish backbones. For approximately the first two weeks she did this work without discomfort. From then on she again experienced discomfort and swelling in the wrist and hand.

She continued to work until midday on September 6, 1984, when she left her job because of the pain and other symptoms in her forearm, wrist and hand, and on the next day she first sought medical treatment for her condition. The doctor diagnosed "[p]robable carpal tunnel syndrome," and later tests confirmed this diagnosis. A few weeks later she had surgery for the condition.

We summarize some important facts. Claimant did not leave her employment at Sally because of the trouble that she was having in her forearm, wrist and hand. She had made no claim, even for medical benefits, under the Workers' Com-

[1] Some of the findings of fact as to dates by the Court of Appeals in this case, *Stovall v. Sally Salmon Seafood*, 84 Or App 612, 735 P2d 18 (1987), are without any support in the evidence and are not in accord with dates that are undisputed by the parties. We shall use dates undisputed by the parties.

pensation Law before she was employed at Hallmark. She was not disabled at the time she applied for work at Hallmark. She performed the duties of her job at Hallmark for over two months before she became disabled.[2]

II.

Claimant filed claims against both Sally and Hallmark for workers' compensation. Each employer denied her

claim. She requested hearings and successfully asked that the hearings be consolidated.

At the hearing, both employers conceded that her claim was compensable, but each contended that the other employer was responsible for payment of compensation. In addition, Hallmark contended that she was estopped from asserting a claim against Hallmark because of her false statement that she had not had previous hand, wrist or arm trouble.

At the hearing, claimant conceded that her answer on the application form was false. Hallmark's plant supervisor testified that had she answered the question truthfully, he would have made inquiry into her work history, and had he learned that she had been having the trouble she did have while working at Sally, he would not have "considered her physically fit for the kind of work for which you were going to hire her." He was not asked directly whether he would have hired her, either at all or for other work.

The report of an examining physician stated in part:

> "In answer to the questions asked, the diagnosis, I am confident, is carpal tunnel syndrome, status post-release, with significant improvement. I do not feel that the condition was idiopathic but arose as a consequence of her work as a crab shaker and was later aggravated further by cod scraping. I feel that her carpal tunnel syndrome first made its clinical appearance while she was working at Sally Salmon Seafood, and was exacerbated by her activities at Hallmark Fisheries, resulting in need for surgical intervention. * * *
>
> "* * * * *
>
> "In July of 1984 she began working at Hallmark Fisheries and problems again started with the right hand, this time much more severe. * * *
>
> "* * * She was working as a cod scraper at the time of recrudescense of symptoms and surgery in 1984."

The referee found that claimant's carpal tunnel syndrome had its inception during her employment at Sally and that there was only a worsening of symptoms from the employment at Hallmark. The referee specifically rejected

[2] If, despite her want of disability, claimant would be considered a person with a physical impairment, Hallmark might have been in violation of ORS 659.425 had Hallmark refused to hire or employ her. That issue was raised by claimant in this matter, but we express no opinion thereon because we do not regard it as being necessary to the decision of this case.

Sally's claim that Hallmark was the responsible employer under the last injurious exposure rule.[3]

On review, the Workers' Compensation Board (Board) stated in its order:

> "[W]e find that claimant's work exposure for Liberty's insured [Hallmark] either contributed to the cause of, aggravated, or exacerbated her underlying *disease*." (Emphasis added.)

The Board stated that it was unconvinced that any one employment was more likely the cause of claimant's "disability." The Board held that the last injurious exposure rule was applicable, thus fixing responsibility on Hallmark. The Board concluded that equitable estoppel should not be applied.

III.

On judicial review, the Court of Appeals affirmed the Board's decision.[4] *Stovall v. Sally Salmon Seafood*, 84 Or App 612, 735 P2d 18 (1987). The court found: (1) Claimant would not have required surgery had she not worked at Hallmark. (2) Working conditions at both employers could have caused the disease. (3) Claimant did not become disabled until she sought medical treatment while working at Hallmark. On those findings the court concluded that Hallmark was the responsible employer under the last injurious exposure rule.

On the issue raised by Hallmark's contention that this claim is barred under the doctrine of estoppel, the Court

of Appeals made no finding of fact whether Hallmark would have hired her had she answered truthfully to the question concerning previous hand, wrist or arm trouble. The court concluded that even if equitable estoppel were available under the Workers' Compensation Law, Hallmark had failed to persuade the court that it would "be appropriate to invoke it here." 84 Or App at 615.

IV.

On the findings made by the Court of Appeals, this is a classic case for application of the last injurious exposure rule. That rule, as it applies to an occupational disease claim, was stated by this court, *Boise Cascade Corp. v. Starbuck*, 296 Or 238, 241, 675 P2d 1044 (1984), as follows:

---

[3] The referee's "OPINION AND ORDER" stated the following under a heading "EVIDENCE":

> "(5) Although she was aware of her problems, she did not accurately indicate their existence to Hallmark when she applied for work (see Ex. 14). Mr. Adams' testimony indicates that the complaint would have been investigated; the existence of a preexisting condition 'sometimes' means the applicant will not be hired. In her case, she would not have been hired."

This is puzzling; we cannot tell whether the last sentence is meant to indicate that Adams' testimony was that claimant would not have been hired. If so, it is not based on Adams' testimony, for he was not asked that question. If the sentence is meant to be a finding of the referee, it is not set forth in the portion of his "OPINION AND ORDER" under the heading "FINDINGS" even though it would have been important to Hallmark's claim of estoppel had there been reason for the referee to reach that claim.

[4] The Court of Appeals reversed a part of the Board's decision pertaining to attorney fees; that issue is not before us.

> "In Oregon, as in most states, the last injurious exposure rule arose in an occupational disease context. We first applied it in a case involving a hearing loss claim. *Inkley v. Forest Fiber Products Co.*, 288 Or 337, 605 P2d 1175 (1980). In an occupational disease context, the rule is this: If a worker establishes that disability was caused by disease resulting from causal conditions at two or more places of employment, the last employment providing potentially causal conditions is deemed to have caused the disease. The result is that, once the requirement of some contributing exposure has been met, the last employer is liable even though the worker has not proved that the last employment was the actual cause of the disability. 288 Or at 342-43. *Accord, Bracke v. Baza'r*, [293 Or 239, 244-249, 646 P2d 1330 (1982)]. *See also* 4 Larson, Workmen's Compensation Law §§ 95.00-95.21 (1983)." (Footnote omitted.)

On these facts and under that rule, Hallmark is the responsible employer for payment of benefits to this claimant on this claim.

V.

Hallmark relies on the doctrine of equitable estoppel to defeat the claim. It is conceded by Hallmark that one of the facts that Hallmark must establish to avail itself of the doctrine is that it changed its position in reliance on claimant's false representation, *i.e.*, that had Hallmark known the truth, it would not have hired her as a cod scraper. As we have already pointed out, 306 Or at 28 n 2, the referee's opinion and order is not clear in this respect. The Board made no finding

on this element of Hallmark's defense. The Court of Appeals' language is similarly unclear:

> "Hallmark asserts that it should be entitled to raise 'estoppel by conduct' as an affirmative defense to responsibility for the claim, because it relied on claimant's representation concerning her health in hiring her and would not have hired her had she provided the correct history of her hand problem. Although claimant was less than candid, she had not sought medical treatment for her condition or lost any work as a result of it. We are not persuaded that, even if equitable estoppel is applicable in the Workers' Compensation context to free an employer of responsibility for a work-related condition, it would be appropriate to invoke it here."

84 Or App at 615. We cannot tell whether the dependent clause of the first sentence was meant by the court to be a part of Hallmark's assertion or a finding by the court. If it were meant to be a part of Hallmark's assertion, the last sentence can be read to mean that Hallmark did not establish the necessary fact to the satisfaction of the Court of Appeals as trier of fact. *Former* ORS 656.298(6).

If the requisite fact of change of position has not been established to the satisfaction of the ultimate trier of fact, *i.e.*, the Court of Appeals, that would end the matter, and there would be no need for us to determine whether the doctrine of equitable estoppel can be utilized to defeat a claim for compensation against an otherwise responsible employer. We shall assume for the sake of argument that the Court of Appeals found the fact to have been established.

The doctrine of estoppel is not of recent origin.

> "'*Estoppe,*' commeth of the French word *estoupe,* from whence the English word stopped: and it is called an estoppel or conclusion, because a man's owne act or acceptance stoppeth or closeth up his mouth to alleage or plead the truth: and *Littleton's* case here proveth this description.
>
> "Touching estoppels, which is an excellent and curious kinde of learning, it is to be observed, that there be three kinde of estoppels, viz. by matter of record, by matter in writing, and by matter *in paiis.*
>
> "[a] By matter of record, viz. by letters patents, fine, recoverie, pleading, taking of continuance, confession, imparlance, warrant of attorney, admittance.

> "[b] By matter in writing, as by deed indented, by making of an acquittance by deed indented or deed poll, [c] by defeasance by deed indented or deed poll.
>
> "By matter *in paiis,* as by liverie, by entry, by acceptance of rent, by partition, and by acceptance of an estate, as here in the case that *Littleton* putteth; whereof *Littleton* maketh a speciall observation, that a man shall be estopped by matter in the countrey, without any writing (1).
>
> "(1) The reasons why estoppels are allowed, seem to be these: No man ought to allege any thing but the truth for his defence, and what he has alleged once, is to be presumed true, and therefore he ought not to contradict it; for as it is said in the 2 Inst. 272. *allegans contraria non est audiendus.* Secondly, as the law cannot be known till the facts are ascertained, so neither can the truth of them be found out by evidence; and therefore it is reasonable that some evidence should be allowed to be of so high and conclusive a nature, as to admit of no contradictory proof. *Note the 11th edition.* - [Note 306.]"

II Coke Upon Littleton 352a (Butler and Hargraves, First American Ed 1853, section 667).[5] Although we have here a written false representation, it is not a writing of the kind to which Littleton referred; rather, the claim of estoppel here is that variously known as estoppel *in pais,* estoppel by conduct or equitable estoppel.[6] Where we use the word "estoppel" hereinafter, it refers to this kind of estoppel unless otherwise specified.

In its purer sense the doctrine of estoppel operates to prevent a person from taking a position contrary to that earlier taken; it prevents a person from proving the truth where that is opposed to a false position earlier taken that caused another to rely on the false position and thereby to choose a course of action.

---

[5] Presently extant is a fourth form known as promissory estoppel. *See, e.g.,* Restatement (Second) Contracts § 90 (1979).

[6] By "matter in pais" (French for "country") the courts originally meant matter that was so notorious that all persons in the vicinity would be expected to have knowledge of the matter.

> "The examples which Coke gives of estoppel by matter in pais are livery of seisin, entry, acceptance of rent, partition, and acceptance of an estate—all acts more or less notorious, of which 'the *pays*' might be expected to have cognizance."

9 Holdsworth's History of English Law 159 (1926).

> "[Equitable estoppel is] employed to prevent one from proving an important fact to be something other than what by act or omission he has led another party justifiably to believe."

Wiggins v. Barrett & Associates, Inc., 295 Or 679, 689, 669 P2d 1132 (1983).[7] When used in that sense, the doctrine would be of no avail to Hallmark. This is because claimant's case does not rest on proving now the true history of her arm, hand and wrist trouble. In other words, her case does not rest on denying the truth of what she represented on the application form.

It is fair to say, however, that the doctrine is not as narrow as the above authorities would suggest. For instance, this court has said:

> "This doctrine of equitable estoppel or estoppel *in pais* is that a person may be precluded by his act or conduct, or silence when it was his duty to speak, *from asserting a right* which he otherwise would have had." (Emphasis added.)

Marshall v. Wilson, 175 Or 506, 518, 154 P2d 547 (1944).[8] "The doctrine of estoppel is only intended to protect those who materially change their position in reliance upon another's acts or representations." *Bash v. Fir Grove Cemeteries, Co.*, 282 Or 677, 687, 581 P2d 75 (1978). It is on the rule as thus stated that Hallmark must rely. In other words, Hallmark

here contends that claimant cannot assert her right to compensation by reason of her false statement and Hallmark's reliance thereon, which we have assumed *arguendo*.

In that broad sense Hallmark would ordinarily be entitled to rely on the doctrine of estoppel to defeat this claim, but we shall now turn our attention to whether a workers' compensation claim may be barred by estoppel.

While acknowledging that the case did not involve an issue whether a claimant may be estopped from successfully presenting a claim, Hallmark contends that our discussion of equitable estoppel in *Frasure v. Agripac*, 290 Or 99, 104-107, 619 P2d 274 (1980), shows that the doctrine is applicable to workers' compensation cases. In that case the Court of

[7] "The gist of equitable estoppel is that a party who has, by his statements or conduct, asserted a claim based on the assumption of the truth of certain facts, whereby he has obtained a benefit from another party, cannot later assert that those facts are not true if thereby the other party will be prejudiced."

McClintock, Equity 80 (2d ed 1948).

In 28 Am Jur 2d, Estoppel and Waiver, section 27, pages 627-28, is found a "comprehensive definition" distilled from a host of cases listed in a footnote to that text:

> "The most comprehensive definition of equitable estoppel or estoppel in pais is that it is the principle by which a party who knows or should know the truth is absolutely precluded, both at law and in equity, from denying, or asserting the contrary of, any material fact which, by his words or conduct, affirmative or negative, intentionally or through culpable negligence, he has induced another, who was excusably ignorant of the true facts and who had a right to rely upon such words or conduct, to believe and act upon them thereby, as a consequence reasonably to be anticipated, changing his position in such a way that he would suffer injury if such denial or contrary assertion was allowed."

[8] The court purported to state this as the rule by quoting from an earlier opinion, namely, *Bramwell v. Rowland*, 123 Or 33, 44, 261 P 57 (1927). The quoted material itself and other language in *Bramwell* not quoted would support only the rule as stated in the authorities in footnote 6 and the accompanying text.

Appeals had held that one employer's insurer, by paying benefits, was estopped by its conduct from later denying a claim on the basis that it was not compensable. We held, in this respect, only that the insurer was not estopped. We did not discuss whether the doctrine of estoppel is available to any party in a workers' compensation case. Finally, we noted on this issue that the insurer had not made a representation normally associated with estoppel.

In answer to questions submitted by this court to decide whether to allow review on this issue, claimant acknowledged that Professor Larson has written:

> "(e) A false statement in an employment application does not of itself make the employment contract invalid. Benefits are barred only if (1) the employee knowingly and wilfully made a false representation as to his physical condition; (2) the employer relied on the representation and the reliance was a substantial factor in the hiring; and (3) there was a causal relation between the false representation and the injury."

1C Larson's Workmen's Compensation Law 8-284, § 47.00 (1986). In elaborating on this "black letter" statement, Larson continues:

> "§ 47.53 False statements in employment application
>
> "On the basis of the distinction stated in § 47.51, it has been held that employment which has been obtained by the making of false statements — even criminally false statements — whether by a minor or an adult, is still employment; that is, the technical illegality will not of itself destroy compensation coverage. What seems to be emerging, in place of a

> conceptual approach relying on purely contractual tests, is a common-sense rule made up of a melange of contract, causation, and estoppel ingredients. The following factors must be present before a false statement in an employment application will bar benefits: (1) The employee must have knowingly and wilfully made a false representation as to his physical condition. (2) The employer must have relied upon the false representation and this reliance must have been a substantial factor in the hiring. (3) There must have been a causal connection between the false representation and the injury." (Footnotes omitted.)[9]

Id. at 8-394. In support of this text the author cites in footnote 24 a lengthy list of cases, continuing into the 1987 supplement. We have examined those cases. Some of them are apparently the source of the rule stated by Professor Larson. Others are cases in which the rule, as stated by him, was applied to various fact situations. In some cases application of the rule worked to deny compensation and in others worked not to deny compensation.

These cases are discussed in terms of fraud except for those from Tennessee. *Foster v. Esis, Inc.*, 563 SW2d 180, 182 (Tenn 1978), seems to say that the Tennessee court would deny benefits by application of the doctrine of estoppel; however, the court does not discuss why it chose to apply "estoppel" rather than fraud or misrepresentation. The cases from

[9] We are not entirely sure what the third element means. If it means that the misrepresentation produced the injury, we think that it would be a rare case indeed that would fit. In the case of an occupational disease, as is the case at bar, certainly the false statement on the employment application did not produce claimant's carpal tunnel syndrome.

the many other jurisdictions cited in the footnote do not mention estoppel but discuss whether the claimant must be barred from recovery by reason of fraud or misrepresentation.

The Tennessee court in *Foster v. Esis, Inc., supra,* in applying the doctrine of estoppel, purported to rely on *Federal Copper & Aluminum Company v. Dickey,* 493 SW2d 463 (Tenn 1973). In that case the court found a public policy declared by the legislature to support adoption of Professor Larson's test. The court noted that Tennessee statutes provided for waiver of workers' compensation coverage for a prospective employee "who is susceptible to an occupational disease or has a history

of heart disease."[10] *Id.* at 464. The court did not use the word "estoppel" at all in its decision except as it appears in the quotation of Larson's test. It held that one is usually prohibited from "profiteering" from his fraud or wilful misrepresentation and that the result should be no different just because the legislature had not anticipated the "problem" presented by such misrepresentation. We are not quite sure how the *Foster v. Esis, Inc.* court translated this into estoppel.

As discussed by both Professor Larson and by the court in *Teixeira v. Kauikeolani Children's Hosp.,* 3 Haw App 432, 652 P2d 635 (1982), there is a split of authority as to whether misrepresentations will bar a claim and, if so, in what circumstances. Some of the courts that permit a claim to be barred have found policy in their respective state statutes that, although not exactly in point, have led the courts to bar claims. Other courts have found no bar because there is no legislative policy one way or the other. Courts which have not referred to legislative policy have split on whether there should be a rule such as that phrased by Professor Larson.

We do not find any decision, not resting on statute, that persuades us one way or the other whether Oregon should follow either line of authority. Especially we find nothing in the cases that would lead us to recognize a defense of estoppel.

VI.

This brings us to what this court should do, now faced for the first time with a contention that the doctrine of estoppel should be employed to defeat a claim. We believe the better approach to be an attempt to discern public policy as expressed by the legislature.

The legislature has made it clear that an employer cannot obtain a valid release of a worker's right to benefits for

injury under the Workers' Compensation Law. ORS 656.236(1) provides:

[10] Compare ORS 656.806, which provides:

"As a prerequisite to employment in any case, a prospective employer may, by written direction, require any applicant for such employment to submit to a physical examination by a doctor to be designated by the Director of the Department of Insurance and Finance, and paid by such prospective employer. In every case in which such right is exercised, and the applicant is subsequently employed, the employer shall file a true copy of the written direction for and the doctor's findings resulting from the physical examination, with the director within 10 days after the beginning of such employment."

"No release by a worker or beneficiary of any rights under ORS 656.001 to 656.794 is valid."

By ORS 656.804 this provision is applicable to claims under the Occupational Disease Law.

The fear that employers or private insurers might attempt to use releases to defeat claims was the reason for inclusion of ORS 656.236(1) in the 1965 major revision of the Workers' Compensation Law. Skelton, *The 1965 Oregon Workmen's Compensation Law*, 45 Or L Rev 40, 47 (1965). It would appear that the policy underlying the legislative injunction against obtaining releases of a worker's rights would extend to forbidding a waiver of those rights if such were sought as a precondition of employment. This policy points in the opposite direction from the Tennessee statute examined in *Federal Copper & Aluminum Company v. Dickey, supra.*[11]

It must be kept in mind that court decisions in cases arising under the Workers' Compensation Law interpret that statutory law. This seems to have been lost on some of the courts whose decisions are cited by Professor Larson, *supra.* Some of those courts obviously arrived at decisions denying benefits because those courts believed that they were free to engraft on the statutory schemes of their respective states the courts' ideas of what the common law or equity might require in the circumstances.

It also must be remembered that the passage of workers' compensation legislation, while giving to the worker the right to compensation regardless of fault, deprived the worker of the right to maintain an action for damages for injuries suffered by reason of the employer's fault. Early on, this court deemed the legislation was for the benefit of the worker. Whether or not it was exclusively so, that concept led this court to pronounce many times over the years that Oregon's statutory workers' compensation scheme was to be construed liberally in favor of the worker-claimant. *See, e.g., Fossum v. SAIF*, 289 Or 787, 792-93, 619 P2d 233 (1980):

"[A]ny such ambiguity must be construed in favor of compensation, just as ambiguous provisions of insurance policies are construed in favor of the beneficiaries, particularly in view of the long-established rule in Oregon that the Workers' Compensation Law must be liberally construed in favor of the worker and compensation. [Citing cases.]"

---

[11] The legislature has directed its attention to the effect of a claimant's false representation to secure benefits, but not to the securing of employment. See ORS 656.990(1), which provides:

"Any person who knowingly makes any false statement or representation to the board or its employes, the director or employes of the director, the insurer or self-insured employer for the purpose of obtaining any benefit or payment under ORS 656.001 to 656.794, either for self or any other person, or who knowingly misrepresents to the board, the director or the corporation or any of their representatives the amount of a payroll, or who knowingly submits a false payroll report to the board, the director or the corporation, is punishable, upon conviction, by imprisonment for a term of not more than one year or by a fine of not more than $1,000, or by both."

Although the issue was not before us, we stated in *Bauman v. SAIF*, 295 Or 788, 794, 670 P2d 1027 (1983), that the insurer might be able to deny the compensability of a claim after first accepting it if "there is a showing of fraud, misrepresentation or other illegal activity." That statement was made, however, in the context of making a claim, not in connection with securing employment.

In short, we understand the philosophy of the Workers' Compensation Law to be that if a person is hired and is, in fact, working for an employer in the role of an employee and becomes disabled as a result of being so employed, the cost of the worker's disability is to be borne by the economy through the employing enterprise and not to be borne by the worker. That statutory policy should not be vulnerable to reopening the way in which a worker in fact obtained the employment when the worker is injured or contracts a disabling occupational disease on the job, perhaps months or years after the event of hiring.

VII.

We conclude that public policy as expressed by the legislature weighs in favor of not defeating a claim for benefits by application of a doctrine not endorsed by the legislature. If false representations by a worker to obtain employment are to defeat a claim for benefits under the doctrine of equitable estoppel, we leave it to the legislature so to provide.

The decision of the Court of Appeals is affirmed.

GILLETTE, J., dissenting.

There are times when enforcing a pre-existing rule of law creates, or at least can appear to create, an injustice, but the rule must nonetheless be enforced. The majority treats

this as such a case. The majority is wrong. There is no pre-existing rule here.

The majority holds — and I agree — that Hallmark is the responsible employer under the last injurious exposure rule, *See Boise Cascade Corp. v. Starbuck*, 296 Or 238, 241, 675 P2d 1044 (1984), unless it is relieved of its responsibility by virtue of its estoppel claim. I also agree with the majority that the Court of Appeals has not given a clear statement as to the facts it has found that bear on the estoppel question. *See Stovall v. Sally Salmon Seafood*, 84 Or App 612, 615, 735 P2d 18 (1987), discussed by the majority at 306 Or ___. That is regrettable, because a clear finding against Hallmark on the facts would obviate any need for a discussion by the majority, or by me, of the estoppel issue. But it must be discussed.

The majority's discussion is at 306 Or ___. It purports to be "an attempt to discern public policy as expressed by the legislature [on the question of whether estoppel is available to parties in Hallmark's position]." 306 Or at ___.

There is no statute directly relating to this issue. The majority purports to find some meaning in the Workers' Compensation Law's prohibition of waivers. ORS 656.236(1); 656.804. 306 Or at ___. The majority does not explain just what the analogy is or means, however. For myself, I do not find any analogy at all between forbidding waivers of coverage by employes, on the one hand, and forbidding a potential employe from obtaining employment (and, subsequently, compensation) by fraud, on the other hand. The legislature simply has not spoken to this question, either directly or by implication.

The majority appears to recognize the same thing, because it concludes its case by relying on the old saw that the

workers' compensation scheme is to be "construed liberally in favor of the worker-claimant." 306 Or at ___, citing *Fossum v. SAIF*, 289 Or 787, 792-93, 619 P2d 233 (1980). This approach works, if at all, only until one backs away a short distance and looks at the resulting proposition. Everyone accepts that the ultimate question is one of legislative intent. The majority announces that it was the legislature's intent, in setting up the workers' compensation system, to permit a worker who *knows* she is physically at risk if she takes a certain job and who *knows* her prospective employer doesn't want to hire her if she

is at risk to *lie*, get the job, get hurt, and charge the employer for her medical expenses, time loss and degree of permanent impairment, if any. And all this in spite of the fact that (it is assumed) the employer has taken every reasonable step to avoid claimant's injury by establishing a *bona fide* condition on hiring and, in all likelihood, has based its workers' compensation insurance plan on the assumption that the condition will be efficacious.

I would hold that one who intentionally conceals a physical condition in response to a valid inquiry by a prospective employer, who would not have been hired for the particular job she was given had she answered truthfully, and who is hired and thereafter is disabled or requires medical services for the concealed condition, is ineligible for workers' compensation benefits. Accord, 1C Larson, *Workman's Compensation Law*, § 47.00, 8-284 (1986). *See Bauman v. SAIF Corporation*, 295 Or 788, 670 P2d 1027 (1983). I would, of course, require the employer or insurance carrier to establish all of the foregoing elements before compensation could be denied.

It is one thing to say that the workers' compensation scheme does not concern itself with fault once a worker is in the system — the trade-off of rights and duties encompassed in the scheme is clear. But this is a case of fraudulently *entering* the system. The legislature has not said it intended to protect or excuse such frauds. The majority is working this unjust result entirely on its own. We do not have to do so.[1]

I dissent.

Peterson, C. J., and Carson, J., join in this dissent.

[1] What should be done is to remand the case to the Court of Appeals to make clear findings on the crucial factual issue. If Hallmark has made its case for estoppel, it should prevail.

INDEX CONTENTS

Overview of Subject Index	714
Subject Index	716
Citations to Court Cases	733
References to Van Natta Cases	740
ORS Citations	743
Administrative Rule Citations	748
Larson Citations	750
Oregon Evidence Code Citations	750
Oregon Rules of Civil Procedure Citations	750
Memorandum Opinions	751
Own Motion Jurisdiction	753
Claimant Index	757

OVERVIEW OF SUBJECT INDEX

AOE/COE

ACCIDENTAL INJURY

AFFIRM & ADOPT
See MEMORANDUM OPINIONS

AGGRAVATION (ACCEPTED CLAIM)

AGGRAVATION (PRE-EXISTING CONDITION)

AGGRAVATION CLAIM (PROCEDURAL)

AGGRAVATION/NEW INJURY
See SUCCESSIVE EMPLOYMENT EXPOSURES

APPEAL & REVIEW
See OWN MOTION RELIEF; REMAND; REQUEST FOR HEARING (FILING); REQUEST FOR HEARING (PRACTICE & PROCEDURE); REQUEST FOR BOARD REVIEW (FILING); REQUEST FOR BOARD REVIEW (PRACTICE & PROCEDURE); REQUEST FOR REVIEW--COURTS (INCLUDES FILING, PRACTICE, PROCEDURE)

ATTORNEY FEES

BACK-UP DENIALS (BAUMAN)
See DENIAL OF CLAIMS

BENEFICIARIES AND DEPENDENTS

BOARD'S OWN MOTION
See OWN MOTION RELIEF

CLAIMS, FILING

CLAIMS, PROCESSING

COLLATERAL ESTOPPEL

CONDITIONS
See OCCUPATIONAL DISEASE, CONDITION, OR INJURY

CONSTITUTIONAL ISSUES

COURSE & SCOPE
See AOE/COE

COVERAGE QUESTIONS

CREDIBILITY ISSUES

CRIME VICTIMS ACT

DEATH BENEFITS

DENIAL OF CLAIMS

DEPENDENTS
See BENEFICIARIES AND DEPENDENTS

DETERMINATION ORDER/NOTICE OF CLOSURE

DISCOVERY

DISPUTED CLAIM SETTLEMENTS
See SETTLEMENTS & STIPULATIONS

DOCUMENTARY EVIDENCE
See EVIDENCE

EMPLOYER'S LIABILITY ACT

EMPLOYMENT RELATIONSHIP

ESTOPPEL

EVIDENCE

EXCLUSIVE REMEDY

FEDERAL EMPLOYEES LIABILITY ACT

FIREFIGHTERS

HEARINGS PROCEDURE
See REQUEST FOR HEARING

HEART CONDITIONS

INDEMNITY ACTION

INMATE INJURY FUND

INSURANCE
See COVERAGE QUESTIONS; EXCLUSIVE REMEDY

INTERIM COMPENSATION
See TEMPORARY TOTAL DISABILITY

JURISDICTION

LABOR LAW ISSUES

LUMP SUM
See PAYMENT

MEDICAL CAUSATION

MEDICAL OPINION

MEDICAL SERVICES

MEDICALLY STATIONARY

MEMORANDUM OPINIONS

NON-COMPLYING EMPLOYER
See COVERAGE QUESTIONS

NON-SUBJECT/SUBJECT WORKERS
See COVERAGE QUESTIONS

OCCUPATIONAL DISEASE CLAIMS (FILING)

OCCUPATIONAL DISEASE CLAIMS (PROCESSING)

OCCUPATIONAL DISEASE, CONDITION, OR INJURY

OFFSETS/OVERPAYMENTS

ORDER TO SHOW CAUSE
See REQUEST FOR HEARING (PRACTICE & PROCEDURE)

OVERPAYMENT
See OFFSETS

OWN MOTION RELIEF

PAYMENT

PENALTIES

PPD (GENERAL)

PPD (SCHEDULED)

PPD (UNSCHEDULED)

PERMANENT TOTAL DISABILITY

PREMATURE CLAIM CLOSURE
See DETERMINATION ORDER; MEDICALLY STATIONARY

PSYCHOLOGICAL CONDITIONS & CLAIMS

REMAND

REQUEST FOR HEARING (FILING)

REQUEST FOR HEARING (PRACTICE & PROCEDURE)

REQUEST FOR BOARD REVIEW (FILING)

REQUEST FOR BOARD REVIEW (PRACTICE & PROCEDURE)

REQUEST FOR REVIEW--COURTS (INCLUDES FILING, PRACTICE, PROCEDURE)

RES JUDICATA

RESPONSIBILITY CASES
See SUCCESSIVE EMPLOYMENT EXPOSURES

SAFETY VIOLATIONS

SETTLEMENTS & STIPULATIONS

SUBJECT WORKERS
See COVERAGE QUESTIONS

SUCCESSIVE (OR MULTIPLE) EMPLOYMENT EXPOSURES

TEMPORARY TOTAL DISABILITY

THIRD PARTY CLAIMS

TIME LIMITATIONS
See AGGRAVATION CLAIM; CLAIMS, FILING; REQUEST FOR HEARING (FILING); REQUEST FOR BOARD REVIEW (FILING); REQUEST FOR REVIEW--COURTS (INCLUDES FILING, PRACTICE, PROCEDURE)

TORT ACTION

VOCATIONAL REHABILITATION

AOE/COE (ARISING OUT OF & IN THE COURSE OF EMPLOYMENT)
See also: COVERAGE QUESTIONS; EMPLOYMENT RELATIONSHIP; HEART CONDITIONS; MEDICAL CAUSATION
Ideopathic vs. unexplained fall, 241

ACCIDENTAL INJURY
See also: CREDIBILITY; MEDICAL CAUSATION
Burden of proof, 432,580
Claim compensable
Asymptomatic before incident, 368
Medical evidence preponderance, 358,492
Multiple traumas, short time, 580
Claim not compensable
Absence of work relationship, 432
Claimant not credible, 486,532,602
No immediate medical attention, 432
Off-job injury, 539
Unwitnessed accident, 532
Vs. occupational disease, 368,458,580,602

AFFIRM & ADOPT See MEMORANDUM OPINIONS (Page 751)

AGGRAVATION CLAIM (PROCEDURAL)
Filing
Letter from claimant as claim, 264
Medical report, necessity of, 264
Own Motion status issue, 53,468
Temporary total disability
Medical verification
Necessity of, 264

AGGRAVATION (ACCEPTED CLAIM)
Burden of proof, 35,115,427,572
Factors discussed
Credibility lacking, 115,427
Diagnosis uncertain, 115
Different body part, 236
Heavy work activity, 427
Inability to work, 77,572
Last arrangement of compensation
Award contemplates fluctuating symptoms, 35,636,638,642
Medical evidence unclear as to, 425
Testimony then and now, 5
Medical verification/inability to work as proof of aggravation, 77
New symptoms, 77
Off-job injury contribution, 547
Surgery, 649
Test: increased loss of earning capacity, 5,35,425
Time loss greater than 14 days, 636,638,642
Waxing and waning symptoms, 632,636
Penalties
Delayed accept/deny, 264
Worsening
Not due to injury, 115,236
Not proven, 5,406,425,427,468,572,636
Proven, due to injury, 35,77,547,638,642,649

AGGRAVATION/NEW INJURY See SUCCESSIVE EMPLOYMENT EXPOSURES

AGGRAVATION (PRE-EXISTING CONDITION)
See also: OCCUPATIONAL DISEASE CLAIMS; PSYCHOLOGICAL CONDITION CLAIMS
Claim compensable
No pre-existing condition found, 253
Pre-existing condition made symptomatic, 368,524
Claim not compensable
Medical evidence insufficient, 458

APPEAL & REVIEW See OWN MOTION RELIEF; REMAND; REQUEST FOR HEARING (FILING); REQUEST FOR HEARING (PRACTICE & PROCEDURE); REQUEST FOR BOARD REVIEW (FILING); REQUEST FOR BOARD BOARD REVIEW (PRACTICE & PROCEDURE); REQUEST FOR REVIEW --COURTS (INCLUDES FILING, PRACTICE, PROCEDURE)

ATTORNEY FEES
As "compensation" discussed, 82,327,331,419,506
"Assessed fee" defined, 407,425,539
Circuit Court vs. Board review, 506,647,683,688,692
"Client-paid fee" defined, 407
"Compensation" discussed, 425
Costs
Approval issue, 359,531,555
Claimant's, reimbursement request, 353,493
On judicial review, 255
Factors considered
Generally, 390,470,501,515
Fee affirmed, awarded, or increased
Assessed fee
Board review, 481,491,501,510
Board review
Expertise, 390
No brief filed, 326
Services for, 95
Circuit Court review, 506
Circuit Court vs. Board review, 683,688,692
Client-paid fee, 42,85,94,95,98,99,101,102,106,353,359,395,425,445, 510,511,515,516
D.C.S., 493
Employer's appeal, compensation not reduced
Extraordinary fee, 470
No brief filed, 72,73,77
Extraordinary fee, 606
Unreasonable conduct
Delay in authorizing surgery, 70
Discovery, failure to provide, 59
Failure to close claim, 476
Failure to pay fee out of compensation, 331
Fee for each such act, regardless of penalty, 401
No penalty, 25,59,70,231,401,476
Penalty assessed, 59,331,401
Fee out of, not in addition to, compensation
Motion for Reconsideration, services for, 85
Own Motion Case, 56,62,64,331
Penalty issue
Failure to pay fee awarded, 331
TTD obtained for claimant, 481

ATTORNEY FEES (continued)
No fee awarded, or fee reduced
Board order final before request made, 109,115,342
Circuit Court action filed late, 647
Employer's request for review
Penalties & fees affirmed, 82,327
Withdrawn or dismissed, 75,393,608
For services in negotiations, 366
Interim order, 336
No employer's appeal, 121,239
No final prevailing, denial of compensability, 85,121,239
No remand by Court to determine issue, 85
No statement of services and/or fee agreement, 395,407,430
Petition for fees to Court of Appeals filed late, 85
Responsibility case
Compensability issue or denial, 53
"Meaningful participation" discussed, 276,608
No carrier-paid fee, 226
One carrier responsible, other pays fee, 35
Unreasonable delay issuing denial, 38
Third party case, 366,380

BACK-UP DENIALS (BAUMAN) See DENIAL OF CLAIMS

BENEFICIARIES & DEPENDENTS
See also: DEATH BENEFITS
Wrongful death vs. Third party actions, 655

BOARD'S OWN MOTION See OWN MOTION RELIEF

CLAIMS, FILING
Late filing issue
Claim not barred, 532
Occupational disease claim
Timeliness issue, 403,580

CLAIMS, PROCESSING
See also: DETERMINATION ORDER; MEDICALLY STATIONARY
Acceptance
Notice of, defined, 521
Scope of, discussed, 674
Duty to process
Claim closure, generally, 476
Independent medical exam: carrier's rights, 280
Non-disabling claim
Misclassification issue, 349
Payment
TTD ordered by Determination Order, denial of, 228
Penalty issue
Delay accept/deny, 401
Delay in authorizing surgery, 70
Denial of TTD ordered by Determination Order, 228
Failure to process timely, 59,231
Improper claim closure, 246,481
Pre-closure denial
Not allowed, 481,521
Premature claim closure
See DETERMINATION ORDER/NOTICE OF CLOSURE; MEDICALLY STATIONARY

COLLATERAL ESTOPPEL
See also: ESTOPPEL; RES JUDICATA
Medical services denial; future services, 117

CONDITIONS See OCCUPATIONAL DISEASE, CONDITION, OR INJURY

CONSTITUTIONAL ISSUES

COURSE & SCOPE See AOE/COE

COVERAGE QUESTIONS
Domestic servants, 236
Non-complying employer issue
Dual employers, compliance found, 234
Non-subject worker issue
Corporate officer, director, 80

CREDIBILITY ISSUES
Board's finding; Referee made none, 409
Inconsistencies: testimony vs. documents, 540,602
Language barrier and, 264
No finding by Referee, 540,547
Referee's opinion deferred to, 389,486,649
Symptoms not reported to physicians, 540
Testimony vs. demeanor, 486

CRIME VICTIMS ACT
Claim denied
No compensable crime, 433
Denial reversed: "sharing the same household" issue, 1
Hearing refused, 575
Remand to consider further evidence, 400
Standard of review, 575
Timeliness issue, 575

DEATH BENEFITS
Burial allowance, 373
Statutory beneficiary vs. estate, 373

DENIAL OF CLAIMS
See also: SETTLEMENTS & STIPULATIONS
Failure to submit to independent medical exam, 280
Medical services issue
Future services, effect on, 5,117
Partial
Determination Order; effect on payments, 674
Generally, 674
Vs. backup, 674
Penalties
Late denial issue, 59,231
Preclosure
Not allowed, 481,521,596
Where new injury occurs, 110

DEPENDENTS See BENEFICIARIES & DEPENDENTS

DETERMINATION ORDER/NOTICE OF CLOSURE
See also: MEDICALLY STATIONARY
Denial of TTD ordered by, 228
Effect of, if unappealed, 423
Necessity of, disabling claim, 349
Payment on; pending appeal, post-partial denial, 674
Penalties issue
Failure to seek Determination Order, 246
Termination of payments on, 674
Premature claim closure issue
Closure affirmed, 26,267
Closure set aside, 8,65,230,246,329,481,524
Factors considered
Change in condition after closure, 355
Condition at time of closure, 329
Evidence not available at closure, 329,355
Expectation of deterioration, 26
Improvement expected, 524
Intervening accident, 8
No medical opinion supporting closure, 8,481
Pain center treatment, 246
Palliative treatment only, 26
Psychological treatment related to injury, 230,345,524
Treating physician's opinion, 26
Weight loss program, 65

DISCOVERY
Claims documents, different claim, 393
Failure to provide, or late provision of
Fee assessed, 59
Independent medical exam: carrier's rights, 280
Impeachment evidence, 59
Penalty
Failure to provide issue, 59

DISPUTED CLAIM SETTLEMENT See SETTLEMENTS & STIPULATIONS

DOCUMENTARY EVIDENCE See EVIDENCE

EMPLOYERS' LIABILITY ACT

EMPLOYMENT RELATIONSHIP
Contract of employment: breach issue, 662
Job offered at PTD hearing, 662
Reinstatement rights (post-injury), 614,644

ESTOPPEL
See also: COLLATERAL ESTOPPEL
Equitable estoppel as defense to claim, 701

EVIDENCE
Cross-examination, medical report
Refused, 110
Exclusion from record issue, 40
Judicial notice issue, 271
Post-hearing submission (to Board), 25
Presumption
Multiple accepted claims/aggravation issue, 596
Treatise, 397
Videotape, claimant's, of his activities, 244

EXCLUSIVE REMEDY
Vocational rehabilitation issue, 693

FEDERAL EMPLOYEES LIABILITY ACT
Amount of damages issue, 244

FIREFIGHTERS

HEARINGS PROCEDURE See REQUEST FOR HEARING (PRACTICE & PROCEDURE)

HEART CONDITIONS

INDEMNITY ACTION

INMATE INJURY FUND

INSURANCE See COVERAGE QUESTIONS; EXCLUSIVE REMEDY

INTERIM COMPENSATION See TEMPORARY TOTAL DISABILITY

JURISDICTION
See also: OWN MOTION RELIEF; REQUEST FOR HEARING (FILING); REQUEST FOR BOARD REVIEW (FILING); REQUEST FOR REVIEW--COURTS
Board
Request for attorney fees not timely, 109,115
Request for Reconsideration not timely, 98
Untimely cross-request; original request withdrawn, 259
Board vs. Circuit Court
Attorney fees, 506,647,683,688,692
Vocational services adequacy issue, 693
Board vs. Court of Appeals
Fee dispute, 387
Penalty issue/Director's order, 387
Reconsideration Request/Petition for Review, 26
Board vs. Hearings Division
Interim Order (Referee's), 57,66
Referee letter: preliminary impressions, 25
Referee's Order of Abatement/Request for Review, 4,93,129,351,370,500,540
Board vs. Workers' Compensation Department
Fee dispute, 387
PPD, 58
Vocational rehabilitation issue, 51,268
Board (Own Motion) vs. Hearings Division
Aggravation issue; rights have run, 53,82,445,446
Board's (Own Motion)
Disabling claim never closed, 349
Motion to Join under; no relief available, 444
Prior order final, 52
Circuit Court
Time to file, 647
Hearings Division
Confusing sequence of orders, issue reserved question, 29
Real party in interest question, 278
Reimbursement of private health carrier, 92
Supplemental Request for Hearing as hearing request, 117

LABOR LAW ISSUES
Contract of employment: breach issue, 662
Job offered at PTD hearing, 662
Reinstatement rights, post-injury, 614,644

LUMP SUM See PAYMENT

MEDICAL CAUSATION
See also: ACCIDENTAL INJURY; OCCUPATIONAL DISEASE CLAIMS; EVIDENCE
Burden of proof, 541
Condition compensable
Continuous symptoms, 474,547
Designation of condition by Board questioned, 44
No other explanation, 596
Off-job incident, 547
Pre-existing condition, injury made symptomatic, 524,580
Preponderance of medical opinion, 580
Pyschological condition caused by doctor's treatment, 12,15,17,20
Symptomatic flareup, 572
Undiagnosed condition, 253
Condition not compensable
Alcoholism, 250
Carpal tunnel/back injury, 271
Credibility lacking, 540
Diagnosis uncertain, 115
Insufficient medical evidence, 551,577,580
Knee/back relationship, 540
Long asymptomatic period, 564
Long period without treatment, 399
Multiple potential causes, 399,564,599
Obesity, 58
Direct & natural consequence issue
Alcoholism/physical injury claim, 250
Hernia surgery/thrombosis, 551
Neck injury resulting from back injury, 45
Obesity: pre-existing, 58

MEDICAL OPINION
Analysis vs. conclusory opinion
Ambiguous, 458
Check-the-box opinion, 430
Conclusory opinion, 474
Explanation of causation lacking, 271
Persuasive analysis, 124,368,430,438,547,558,599
Relationship unexplained, 599
Treating physician, conclusory opinion, 11,115,577
Unaware of work, off-work activity, 271
Based on
Adversarial attitude, 250
Before & after key event observation, 110,580,660
Consistent with whole record, 368
Credibility (claimant's) questionable, 414,486,540
"Direct" vs. "indirect" relationship, 580
Greater expertise, 411
Incomplete or inaccurate history, 399,414,458,474,540,580,596
Multiple examinations, 580,660
No objective evidence, 87
Possibility vs. probability, 271,447,564
Sufficient history, 547
Time of examinations, 5,516,596
Undiagnosed condition, 253
Treating physician
Assumes treatment long after injury, 399
Inconsistencies in, 26
Observation over time vs. one-time evaluation, 124,378,547
Surgery issue, 124
Weight, generally, 5,26,87,345,430,438,474,517,599

MEDICAL SERVICES
Alcoholism treatment, 250
Alternative service offered, 409
Back rehabilitation program, 409
Breast reduction surgery, 39
Burden of proof, 5,8,87,430,572,599
Chiropractic treatment
Compensable
Condition related to injury, 8
No contrary evidence, 554
Palliative, 528
Preponderance of medical opinion, 438,474
Not compensable
Claimant working without treatment, 11
Conclusory opinion, 11
Doesn't enable claimant to work, 5,57,565
No material benefit, 87,599
No referral from treating physician, 565
Preponderance of medical opinion, 87
Scheduled vs. as needed, 5,11
Treatment detrimental, 87
DCS: effect on disputed billings, 278
Harmful treatment compensable, 12,15,17,20
Independent medical examination: carrier's rights, 280
Malpractice, 653
Mileage reimbursement, 474
Misdiagnosis, treatment for, 12,15,17,20
Pain Center treatment, 246,250
Palliative treatment discussed, 5
Penalty issue
Delay in authorizing surgery, 70
In relation to fee dispute, 387
Late payment; bill not received, 401
No payment, no denial, 554
Preventive, 281
Surgery
Not reasonable, necessary, 124,430
Reasonable & necessary, 345,347,524
Refusal of, 568
Weight loss program, 58,65

MEDICALLY STATIONARY
See also: DETERMINATION ORDER/NOTICE OF CLOSURE
Premature Claim Closure issue
Condition at closure, 329
Evidence not available at closure, 329,355
Expectation of deterioration, 26
Improvement expected, 524
No medical evidence supporting closure, 481
Palliative treatment only, 26
Post-closure reports, 267
Psychological treatment related to injury, 230,524
Treating physician's opinion, 26
Weight loss program, 65

MEMORANDUM OPINIONS See page 751

NON-COMPLYING EMPLOYER See COVERAGE QUESTIONS

NON-SUBJECT/SUBJECT WORKERS See COVERAGE QUESTIONS

OCCUPATIONAL DISEASE CLAIMS (FILING)

OCCUPATIONAL DISEASE CLAIMS (PROCESSING)
See also: AGGRAVATION (PRE-EXISTING CONDITION); CLAIMS, FILING; HEART CONDITIONS; PSYCHOLOGICAL CONDITIONS; SUCCESSIVE EMPLOYMENT EXPOSURES
Burden of proof, 271,411,418,447,458,558,589
Claim compensable
Greater expert supports claim, 411
Medical evidence preponderance, 520
Symptoms requiring treatment, 12,15,17,20
Undiagnosed condition, 250
Claim not compensable
Medical opinion not supportive, 447,458,558
No treatment, TTD, 418
No worsening of condition, 418,589
Symptoms increased with no work, 447
Symptoms requiring treatment, 12,15,17,20
Undiagnosed condition, 250
Vs. accidental injury, 368,458,580,602

OCCUPATIONAL DISEASE, CONDITION, OR INJURY
Adjustment disorder, 20
Alcoholism, 250
Allergies, 589
Ankylosing spondylitis, 674
Asbestosis, 281
Asthma, 505,572
Atopic diathesis, 589
Atypical somatoform disorder, 12,15,17
Carpal tunnel syndrome, 271,447,701
Chemical poisoning, 558
Coronary atheroschlerosis, 505
Deep vein thrombosis, 551
Degenerative talonavicular joint, 514
Hemorrhoids, 418
Hernia, 551
Isocyanate exposure, 49
Obesity, 58
Osteochonditis, 492
Osteolysis, 568
Panic disorder, 20
Pneumonia, 572
Rhinitis, 562
Somatization disorder, 558
Spondylolisthesis, 368,458
Stenosing tenovaginitis, 577

OFFSETS/OVERPAYMENTS
Allowed
TTD paid after end of ATP, before Determination Order, 5
TTD vs. TTD, 25
Disallowed
Disability benefits (collective bargaining agreement), 231
Pre-closure, 481
Unilateral, 231

ORDER TO SHOW CAUSE See REQUEST FOR HEARING (PRACTICE & PROCEDURE)

OVERPAYMENTS See OFFSETS

OWN MOTION RELIEF
(See Page 753 for a list of unpublished Board decisions under Own Motion Jurisdiction.)
Appeal rights, 537,586
Attorney fees See ATTORNEY FEES
Claims affected by new legislation, 537,586
Consent to Issuance of .307 Order issue, 325,359,437,467,509
Relief allowed
PPD request, 127
Reopening request/TTD
After TTD in another claim stopped, 356
Disability payments, another state, 62
Hospitalization or surgery, 56,62,64,74,122,325,329,333,354,356,360,437,457,473,508
Receiving Social Security, 447
Stipulation as bar, 64
Work force, no withdrawal from, 358,360,439,447,456,464,588
Relief denied
Motion to Join, 444
PPD request, 70,76,94,352,457
PTD request, 62,64,83,354,537
Reopening request/TTD
Claimant receiving Social Security, 344,537
Diagnostic workup, 355,356,458
No hospitalization or surgery, 58,76,82,94,99,128,348,351,353,356,452,455,456,466,467,508,509,520,532,586
No medical authorization of TTD, 344
No worsening, 355
Premature request, 510
Withdrawal from work force, 80,83,351,365,380,385,466

PAYMENT
Determination Order: pending appeal, 674
D.C.S. distribution, 493
Interim compensation: pending appeal, 291,659
Penalties
Failure to pay D.O. pending appeal, 674
Referee's order, refusal of, 674

PENALTIES
See also: Subject headings for which penalties are assessed
As "compensation" discussed, 82,327
"Compensation" discussed, 419,674
Compensation "then due" requirement, 264,401
Double penalty, 59,401

PPD (GENERAL)
Burden of proof, 423,429
Penalty
Late payment of award, 92

PPD (SCHEDULED)
Affected body part
Arm, 513,577
Foot, 391
Knee, 264,429
Leg, 391,453,516
Burden of proof, 453,577
Factors considered
Credibility, 264,516
Limits on activities, 391,453
Mechanical impairment, 391
Minimal impairment, 516
No loss of use or function, 577
Pain, 453
Testimony, 513

PPD (UNSCHEDULED)
Back & neck
No award: 58,389,429,562
5-15%: 124
20-30%: 30,378,383,556
35-50% 385,453,543
55-100%: 49
Body part affected
Lungs, 49
Psychological condition, 385
Rhinitis, 562
Shoulder, 513,568
Burden of proof, 429,453
Factors considered
Age
Under 30: 124,383
31-39 years: 378,543,568
40-50 years: 30
51+ years: 49,385,453,556
Education
7-11 years: 49,124,385,453,543,556
12th grade/GED: 30,378,383
Higher education, 568
Impairment
Disabling pain, 124
Limited to less than 40 hours/week, 383
Lung capacity reduced, 49
Mild, 378
Mildly moderate, 513
Minimal, 30,124
Multiple physicians find no limits, 389
Non-compensable condition prevents work, 556
None, 429
Not due to compensable injury, 577
Not permanent, 562,577
Prior injuries, 543
Unreasonable refusal of treatment, 568
Motivation
Refusal to cooperate with vocational services, 49
Refusal to take precautions, 562
Pre-existing condition
Heart condition, 556
Obesity, 58
Work experience
Heavy work only, 543
Limited to light work, 453
One field, now precluded or limited, 49,385
Reduction in wages post-injury, 383
Release to return to regular work, 389
Sales, 513
Varied experience, largely precluded, 378

PERMANENT TOTAL DISABILITY
Award
Affirmed, 624,631
Reduced, 49
Refused, 440,513,556,662
Effective date, 624
Factors considered
Age
51+ years: 49,440,556,624
Education
7-11 years: 49,440,556
12th grade or GED, 513
Job offered at hearing, 662
Last arrangement of compensation
Permanent worsening since, 624
Medical condition/opinion/treatment
Claimant capable of work, 49,440,513
Non-compensable condition prevents work, 556
Severe impairment, 624
Motivation See also: Vocational Assistance/Opinion (below)
"Futility doctrine" discussed, 440
No work search, 440,624
Reserved, non-communicative claimant, 49
Pre-existing condition
Post-injury worsening, 556
Vocational assistance/opinion
Claimant employable, 49
Cooperation
Questioned, 49
Own Motion case, 633
Two claims: which responsible for, 631

PREMATURE CLAIM CLOSURE See DETERMINATION ORDER; MEDICALLY STATIONARY

PSYCHOLOGICAL CONDITION CLAIMS (including claims of stress-caused conditions)
Occupational disease claim
Claim compensable
Fairly imposed discipline, 257
Symptoms vs. worsening, pre-existing condition, 257
Claim not compensable
Major contributing cause test, 580
Relationship to physical injury claim
Doctor-induced, harmful, 12,15,17,20
Material relationship test, 524,606
Pre-existing condition, 580,606
Uncontradicted medical opinion, 524
Symptoms vs. condition, 606

REMAND
By Board
Motion for, allowed
Cross-exam; report offered at hearing, 338
Due diligence test met, 106,338,393
For hearing, 403
Post-hearing death of claimant, 545
Referee's order not final, 376
Referee's order not sent to all parties, 374,384
Surgery reports, 114,370,545
Motion for, denied
Evidence not material, 505
Evidence obtainable with due diligence, 44,75,90,91,397,532,551, 568,609
Record not incomplete (exclusion of evidence), 40,96,397,532,580, 606,609
Record not incompletely developed, 373,385
Supplemental Request for Hearing vests jurisdiction, 117
To complete record, 4,74,118,326
To consider settlement, 128
To develop record (dismissal issue), 396,423,442
To reconvene hearing (transcript unavailable), 121,123,333,334
By Court of Appeals
Request for, denied, 635
Scope of, 445
To accept aggravation claim, 100
To accept claim, 38,39,42
To accept condition,3,45,65,101
To determine
Good cause/late filing, 22
Permanent disability, 385
Surgery question/new medical evidence, 345,628
To reconvene hearing, 547
Whether dismissal appropriate, 280
Whether Referee's order mailed, 629
To dismiss Request for Hearing, 278
To make findings of fact, conclusions of law, 616
To provide treatment, 65,472
To set aside Determination Order, 345
"Parties" discussed, 374

REQUEST FOR HEARING (FILING)
Late filing issue
Aggravation claim, 468
No copy of denial to attorney, 22,114
180-day limit, 117
Penalties and fees issue, 476
Real party in interest question, 278
Supplemental request as independent request, 117

REQUEST FOR HEARING (PRACTICE & PROCEDURE)
Determination Order appeal, claimant not stationary, 423,442
Dismissals: policy re: prejudice/without prejudice, 423,437,442

REQUEST FOR BOARD REVIEW (FILING)
Abatement, Referee's Order of/Request for Review, 4,93,129,351,370, 378,500,540
Cross-request
Necessity for, 259
Dismissal of
No timely notice to all parties, 63,335,337,443,465
Premature, 93,351,397
Unrepresented claimant, 63,67
Untimely filing, 12,43,48,100,105,109,335,337,365,443,465,499,536, 595,696,700
Withdrawn, 75
Dismissal, Order of, set aside, 83,349,357
Final order of Referee
Necessity of, 57,376
What constitutes, 25,57,66,376,397
"Filing" discussed, 83,100,105,109,408,466,540,696
Mailing vs. receipt of order by parties, 629
Motion to Dismiss
Allowed
Cross-request untimely; request withdrawn, 259
Despite incorrect statement of appeal rights, 387
Director's final order, 387
No statutory beneficiary, 373
No timely notice to all parties, 43,343,371,594
Untimely filing, 67,472
Denied
Timely appeal from amended order, 84
Timely filing, 408,466,471
Timely notice to all parties, 105,336,363,471,489,511
"Parties" discussed, 336,363,374,376,489,511,536
Unrepresented claimant, 465

REQUEST FOR BOARD REVIEW (PRACTICE & PROCEDURE)
Brief, filing
Necessity of, 72
Reply brief as appellant's brief issue, 67
Served on wrong party, 602
Condition ordered accepted questioned, 44
Issue
Not raised at hearing, 353,373
Mailing vs. receipt of order by parties, 629
Motion to join Own Motion claim, 444
Penalty issue
Delay in payment following Board order, 35
Reconsideration Request
Denied
Not timely, 12,98
Order abated, 129,130
Scope of Review
All issues raisable based on record, 51
Limited to record developed at hearing, 25

REQUEST FOR REVIEW--COURTS (INCLUDES FILING, PRACTICE & PROCEDURE)
Dismissal
No notice to all parties, 227
"Final order" defined, 616
Scope of Review: Court of Appeals
As affecting substantive rights, 616
Effective date, 616
Service on attorney as service on party, 281
Substantial evidence review discussed, 616

RES JUDICATA
Application to administrative proceeding, 284
Discussed, generally, 284,476
Prior litigation
Issue not raisable, 403
Issue not ripe, 284,672
Issue ripe, not barred, 96,476
Medical services denial, future services, 117

RESPONSIBILITY CASES See SUCCESSIVE (OR MULTIPLE) EMPLOYMENT EXPOSURES

SAFETY VIOLATIONS

SETTLEMENTS & STIPULATIONS
Disputed claim settlement
As judgement, 476
Distribution, 493
Effect on Third Party distribution, 450
Enforcement, medical service provider, 278
Questioned, 119
Vs. illegal release, 366
Vs. release, 119
Interpretation by Board, 29
Remand request, "raised or raisable" issue, 606

SUBJECT WORKERS See COVERAGE QUESTIONS

SUCCESSIVE (OR MULTIPLE) EMPLOYMENT EXPOSURES
Aggravation/new injury
Aggravation found, 35,110,421
Burden of proof, 414,421
Complex medical question, 414
Continuous symptoms, 35,421
First claim in open status, 110
Neither found, 406
New injury found, 414
Own Motion claim vs. new injury: 1st responsible, 53
Questionable credibility, 414
Test
Independent contribution, later employment, 35,53,406,414,421
Last injurious exposure rule
As affirmative defense, 261
As rule of assignment of liability, 261
As rule of proof, 261
Date of disability, 261,458,545
Equitable estoppel as defense, 701
First employer responsible, 261
Later employer responsible, 458,545,701
Multiple accepted claims
First employer responsible, 660
Presumption, 596,660
Second employer responsible, 596
Multiple employment exposures
Oregon/out-of-state, 52
Responsibility cases
Multiple accepted claims
First employer responsible, 660
Presumption, 596,660
Second employer responsible, 596
Own Motion claim: Board's consent to .307 Order, 325
Penalty issue
Employer responsibility to initiate .307 proceeding, 226
Reimbursement issue
No .307 order; TTD and vocational services, 622
"Worsening" discussed, 414

TEMPORARY TOTAL DISABILITY
Denial of; after Determination Order, 228
Disability benefits (collective bargaining agreement) vs. TTD, 231
Entitlement (See also: AGGRAVATION CLAIM; OWN MOTION JURISDICTION)
After Referee's reversal (denial); before Determination Order, 239
Aggravation vs. original claim, 264
Burden of proof, 649
During Pain Center treatment, 246
Full vs. trial release, 502
Physical inability to work vs. unavailable, 246
"Regular employment" defined, 502
"Retirement" discussed, 274,649
Two open claims, simultaneous, 356
Where receiving out-of-state disability payments, 62
Withdrawal vs. retirement, 649
Interim compensation
As "compensation", 291,659
Entitlement
Where working, 291,659
Payment pending appeal, 291
Penalty issue
Failure to pay, 59,291,659
Rate
Bonuses, 568
"Injury" date: disease vs. injury, 602
Overtime, 568
Part-time, varying hours, 620
Penalty issue, 568
Regular employment vs. varying hours, wages, 41
"Wages" defined, 568
Reimbursement issue, WCD to carrier, 268
Temporary partial disability
Unemployment benefits as wage earnings, 398
Termination
Penalties issue, 239,481,502,518
Unilateral
Following incarceration, 481
Following litigation order, 239
Release to return to regular work, 502,561
Withdrawal from work force, 518
Unemployment benefits--SEE temporary partial disability, this heading

THIRD PARTY CLAIMS
Assignment of cause of action issue, 495,593
Distribution issue
After final determination of PPD, 413
Carrier's lien vs. children's share of estate, 102,339,655
Costs to insurer exceed balance, 366
Deferred for final determination of PPD, 68
D.C.S.: effect on, 450
Premature request, 381
Statutory distribution, 450,495
Unpaid medical bills, 450
Interest on delayed payment, 381
Off-job injury previous to job injury, judgement for, 45
Paying agency's lien/expenditures
Future expenses, 31,45,361,480
Reconsideration request
Denied, 593
Due diligence rest, 480
Right of election issue, 495,593
Settlement issue, 34,68,108,366,488

TIME LIMITATIONS See AGGRAVATION CLAIM; CLAIMS, FILING; REQUEST FOR HEARING (FILING); REQUEST FOR BOARD REVIEW (FILING); REQUEST FOR REVIEW--COURTS (INCLUDES FILING, PRACTICE & PROCEDURE)

TORT ACTION
See also: EXCLUSIVE REMEDY

VOCATIONAL REHABILITATION
See also: JURISDICTION
Civil suit/exclusive remedy case, 693
Remibursement, out-of-state program, 268

CITATIONS TO COURT CASES

COURT CASE----------PAGE(S)

Adsitt v. Clairmont Water District, 79 Or App 1 (1986)------110,257,580, 606
Agripac v. Kitchel, 73 Or App 132 (1985)------75,393,608
Aguiar v. J.R. Simplot Co., 87 Or App 475 (1987)-------3,58,85,425
Allie v. SAIF, 79 Or App 284 (1986)-----551
Alvarez v. GAB Business Services, 72 Or App 524 (1985)------267,329,355
Anderson v. Publishers Paper, 78 Or App 513 (1986)------22
Anderson v. West Union Village Square, 43 Or App 295 (1980)-----572
Anfora v. Liberty Communications, 88 Or App 30 (1987)------276
Aquillon v. CNA Ins., 60 Or App 231 (1982)------8,524
Argonaut Ins. v. King, 63 Or App 847 (1983)------43,43,48,63,67,83,100,105, 109,335,336,337,343,363,365,370,371,376,408,443,465,466,471,472,489, 511,594
Armstrong v. Asten-Hill, 90 Or App 200 (1988)------629,635
Armstrong v. SAIF, 58 Or App 602 (1982)------629
Armstrong v. SAIF, 65 Or App 809 (1983)------374,384
Armstrong v. SAIF, 67 Or App 498 (1984)------629
Bahler v. Fletcher, 257 Or 1 (1970)------284
Bales v. SAIF, 294 Or 224 (1982)------257
Bandy v. Norris, Beggs & Simpson, 222 Or 1 (1959)------284
Barrett v. D & H Drywall, 300 Or 553 (1987)-----250,556,577
Bash v. Fir Grove Cemeteries, 282 Or 677 (1978)------701
Bauman v. SAIF, 295 Or 788 (1983)-----284,521,596,606,674,701
Bennett Trust Co. v. Sengstacken, 58 Or 333 (1911)------616
Berry Transport v. Heltzel, 202 Or 161 (1954)------616
Blackman v. SAIF, 60 Or App 446 (1982)------480
Blakely v. SAIF, 89 Or App 653 (1988)------447,458,558,589
Blankenship v. Union Pacific Railroad, 87 Or App 410 (1987)------244
Bloomfield v. National Union Ins., 72 Or App 126 (1985)-----580
Boise Cascade v. Jones, 63 Or App 663 (1983)------228
Boise Cascade v. Starbuck, 296 Or 238 (1984)------110,261,421,545,602,701
Boise Cascade v. Wattenbarger, 63 Or App 447 (1983)------580
Bold v. SAIF, 60 Or App 392 (1982)------502
Bono v. SAIF, 298 Or 405 (1984)------264,291,659
Bowser v. Evans Products, 17 Or App 542 (1974)------284
Boyce v. Sambo's Restaurant, 44 Or App 305 (1980)------391
Bracke v. Baza'r, 293 Or 239 (1982)------261,545,701
Bracke v. Baza'r, 294 Or 483 (1983)------683
Bradshaw v. SAIF, 69 Or App 587 (1984)------432,551
Bramhall v. ICN Medical Laboratories, 284 Or 279 (1978)-------662
Bramwell v. Rowland, 123 Or 33 (1927)------701
Brooks v. D & R Lumber, 55 Or App 688 (1982)------572
Brown v. AFSD, 75 Or App 98 (1986)------616
Burkholder v. SAIF, 11 Or App 334 (1972)-----117
Bush v. SAIF, 68 Or App 230 (1984)------649
Butcher v. SAIF, 45 Or App 313 (1980)------440,624
Cain v. Woolley Enterprises, 83 Or App 213 (1986)------628
Cain v. Wooley Enterprises, 301 Or 650 (1986)------338
Carr v. Allied Plating, 81 Or App 306 (1986)------96,117,476
Carter v. Moberly, 263 Or 193 (1972)------244
Cary v. Burns, 169 Or 24 (1942)------662

CITATIONS TO COURT CASES

COURT CASE----------PAGE(S)

Cavins v. SAIF, 272 Or 162 (1975)------689
Chatfield v. SAIF, 70 Or App 62 (1984)------524
Clark v. Boise Cascade, 72 Or App 397 (1985)------513
Clark v. Erdman Meat Packing, 88 Or App 1 (1987)------271,447,458,558,589
Clemons v. Roseburg Lumber, 34 Or App 135 (1978)------568
Coastal Farm Supply v. Hultberg, 84 Or App 282 (1987)------486
Collins v. Hygenic Corp., 86 Or App 484 (1987)------12,15,17,20,589
Compton v. Weyerhaeuser, 301 Or 641 (1986)------338
Compton v. Weyerhaeuser, 302 Or 366 (1986)------255
Consolidated Freightways v. Poelwijk, 81 Or App 311 (1986)------403,649
Cowart v. SAIF, 86 Or App 748 (1987)------22,114
Crowe v. Jeld-Wen, 77 Or App 81 (1985)------368
Cutright v. Weyerhaeuser, 299 Or 290 (1985)-------62,83,274,328,344,365, 380,385,456,464,466,537,588,649
Davison v. SAIF, 80 Or App 541 (1986)------349,476
Dean v. Exotic Veneers, 271 Or 188 (1975)------284,476
DeMarco v. Johnson Acoustical, 88 Or App 439 (1987)------100
Denny v. Hallmark Fisheries, 88 Or App 409 (1987)-----101,250
Destael v. Nicolai Co., 80 Or App 596 (1986)------51,58
Dethlefs v. Hyster Co., 295 Or 298 (1983)------271,411,418,447,458,558.580, 589
Donaca v. Curry Co., 303 Or 30 (1987)------662
Donald Drake Co. v. Lundmark, 53 Or App 261 (1983)------602
Dotson v. Bohemia, 80 Or App 233 (1986)------82,327,419,506
Dunn v. SAIF, 306 Or 8 (1988)------696
Dunn v. SAIF, 88 Or App 291 (1987)------700
Duran v. SAIF, 87 Or App 509 (1987)------38
EBI v. Freschette, 71 Or App 526 (1984)-----119
Eder v. Pilcher Construction, 89 Or App 425 (1988)------370
Edward Hines Lumber v. Kephart, 81 Or App 43 (1986)------633
Edwards v. SAIF, 30 Or App 21 (1977)------551
Elwood v. SAIF, 298 Or 429 (1985)------257
Emery v. Adjustco, 82 Or App 101 (1986)------502
Estate of Troy Vance v. Williams, 84 Or App 616 (1987)------68,102,339,361, 366,450
Evans v. Rookard, 85 Or App 213 (1987)------276
Farmers Ins. Group v. SAIF, 301 Or 612 (1986)------84,370,499,536,595,683, 689
Fenton v. SAIF, 87 Or App 78 (1987)------45,551
Fink v. Metropolitan Public Defender, 67 Or App 79 (1984)-----231
Fischer v. SAIF, 76 Or App 656 (1985)------26,84,370,499,536,595
Fleming v. Daeuble Logging, 89 Or App 87 (1987)------26,58
Ford v. SAIF, 71 Or App 875 (1985)------532
Fossum v. SAIF, 289 Or 787 (1980)------701
Fraijo v. Fred N. Bay News, 59 Or App 260 (1982)-----124,385,453,513,556
Frasure v. Agripac, 290 Or 99 (1980)------701
FMC Corp. v. Liberty Mutual Ins., 70 Or App 370 (1984)------458
Fromme v. Fred Meyer, 88 Or App 306 (1987)------255
Fromme v. Fred Meyer, 89 Or App 397 (1988)------502
Garbutt v. SAIF, 297 Or 148 (1984)------264,389,577
Gaul v. Tourtellotte, 260 Or 14 (1971)------284

CITATIONS TO COURT CASES

COURT CASE----------PAGE(S)

Geentry v. Hyster, Inc., 23 Or App 146 (1975)------458
Georgia-Pacific v. Awmiller, 64 Or App 56 (1983)------476,502
Georgia-Pacific v. Hughes, 85 Or App 362 (1987)------291,659
Georgia-Pacific v. Hughes, 305 Or 286 (1988)------674
Georgia-Pacific v. Piwowar, 86 Or App 82 (1987)------228,231,674
Georgia-Pacific v. Piwowar, 305 Or 494 (1988)------606
Georgia-Pacific v. Roff, 80 Or App 78 (1986)------427,596
Getchell v. Mansfield, 260 Or 174 (1971)------653
Gettman v. SAIF, 289 Or 609 (1980)------516
Ginter v. Woodburn United Methodist Church, 62 Or App 118 (1983)----518
Globe Machine v. Yock, 79 Or App 9 (1986)------250
Grable v. Weyerhaeuser, 291 Or 387 (1981)------547,572,636
Grace v. SAIF, 76 Or App 511 (1985)------250,606
Gray v. SAIF, 70 Or App 313 (1984)------568
Greenslitt v. City of Lake Oswego, 88 Or App 94 (1987)------506,539,683, 688,689
Groshong v. Montgomery Ward, 73 Or App 403 (1985)------96,397,505
Grudle v. SAIF, 4 Or App 326 (1971)------689
Guill v. Pendleton Woolen Mills, 305 Or 538 (1988)------683,688,689
Gunter v. Mersereau, 7 Or App 470 (1971)------236
Gwynn v. SAIF, 304 Or 345 (1987)------35,77,246,572,632,636,638,642,649
Gwynn v. SAIF, 91 Or App 84 (1988)------636,642
Hall v. Home Insurance, 59 Or App 526 (1982)------458
Hansen v. Weyerhaeuser, 89 Or App 349 (1988)-----472
Harp v. Loux, 54 Or App 840 (1981)------22
Harris v. Albertson's, 65 Or App 254 (1983)------458,524,580
Harwell v. Argonaut Ins., 296 Or 505 (1984)------30,49,124,378,383,385,429, 453,513,556,568
Hayes-Godt v. Scott Wetzel Services, 71 Or App 175 (1984)-----580
Hedlund v. SAIF, 55 Or App 317 (1981)-----547
Hensel Phelps Construction v. Mirich, 81 Or App 290 (1986)------35,53,110, 414,421
Hoag v. Duraflake, 37 Or App 103 (1978)------276,633
Holien v. Sears, Roebuck, 298 Or 76 (1984)------644
Holmes v. SAIF, 38 Or App 145 (1979)------616
Home Plate, Inc., v. OLCC, 20 Or App 188 (1975)------616
Howerton v. SAIF, 70 Or App 99 (1984)------49,568
Hubble v. SAIF, 57 Or App 513 (1982)------683
Humphrey v. SAIF, 58 Or App 360 (1982)------486
Hutcheson v. Weyerhaeuser, 288 Or 51 (1979)------389,429,432,486,516,540, 551,589,599
Industrial Indemnity v. Kearns, 70 Or App 583 (1984)------596,660
Ingram v. AMFAC, 73 Or App 197 (1985)------647
Inkley v. Forest Fiber Products, 288 Or 337 (1980)------532,545,580,701
International Paper v. Turner, 304 Or 354 (1987)------642
International Paper Co. v. Wright, 80 Or App 444 (1986)------12,26,84,98, 109,115,342,370,499,536,595
Jackson v. SAIF, 7 Or App 109 (1971)------481,502,518
James v. Kemper Ins., 81 Or App 80 (1986)------87,124,430,524,599
James v. SAIF, 290 Or 343 (1981)------458,602
James River Corp. v. Youngblood, 80 Or App 472 (1986)------421

CITATIONS TO COURT CASES

COURT CASE----------PAGE(S)

Jameson v. SAIF, 63 Or App 553 (1983)------580
Janzen v. Sunriver Lands, Inc., 83 Or App 510 (1987)------614
Jeld-Wen v. Page, 73 Or App 136 (1985)------606
Jenkins v. Tandy Corp., 86 Or App 133 (1987)------39
Johnson v. SAIF, 78 Or App 143 (1986)------616
Johnson v. Spectra Physics, 303 Or 49 (1987)------284,521,606,609,674
Jones v. Emanuel Hosp., 280 Or 147 (1977)------59,291
Jones v. Flannigan, 270 Or 121 (1974)------284
Jordan v. SAIF, 86 Or App 29 (1987)------110,250,572
Joseph v. Lowery, 261 Or 545 (1972)------616
Karr v. SAIF, 79 Or App 250 (1986)------83,274,328,365,380,385,464,466,537, 649
Kassahn v. Publishers Paper, 76 Or App 105 (1985)------411,418,458,524,551, 580
Kemp v. Workers' Compensation Dept., 65 Or App 659 (1983)------554,565
Kepford v. Weyerhaeuser, 77 Or App 363 (1986)------284
Kienow's Food Stores v. Lyster, 79 Or App 416 (1986)------5,53,75,90,91, 338,397,551,580
Knapp v. City of North Bend, 304 Or 34 (1987)------614,644
Krajacic v. Blazing Orchards, 84 Or App 127 (1987)------264,468
Les Schwab Tire Center v. Elmer's Pancake House, 84 Or App 425 (1987)---239
Lester v. Weyerhaeuser, 70 Or App 307 (1984)------476,568
Lindamood v. SAIF, 78 Or App 15 (1986)------25,57,66,376,397
Lobato v. SAIF, 75 Or App 488 (1985)------458
Locke v. SAIF, 21 Or App 725 (1975)------547,624
Loehr v. Liberty Northwest Ins., 80 Or App 264 (1986)------492
Long v. Storms, 52 Or App 685 (1981)-----255
Maarefi v. SAIF, 69 Or App 527 (1984)-----329
Majors v. SAIF, 3 Or App 505 (1970)------373
Manous v. Argonaut Ins., 79 Or App 645 (1986)-----547
Marshall v. Wilson, 175 Or 506 (1944)------701
Martin Engineering v. Opton, 277 Or 291 (1977)------244
Matthews v. Louisiana Pacific, 47 Or App 1083 (1980)------250
May v. May, 55 Or App 396 (1981)------22
McAdams v. SAIF, 66 Or App 415 (1984)-----241
McBroom v. Chamber of Commerce of the U.S., 77 Or App 700 (1986)-----495
McClendon v. Nabisco Brands, 77 Or App 412 (1986)------378,458,580,589
McGarrah v. SAIF, 296 Or 145 (1983)------447,458,558,589
McGarry v. SAIF, 24 Or App 883 (1976)------87,124,346,528
McGill v. SAIF, 81 Or App 210 (1986)------647
Mendenhall v. SAIF, 16 Or App 136 (1974)------25,57,66,376
Milburn v. Weyerhaeuser, 88 Or App 375 (1987)------432,540,551,599
Miller v. Granite Construction, 28 Or App 473 (1977)------547,580
Million v. SAIF, 45 Or App 1097 (1980)-----96,284,403,476
Mischel v. Portland General Electric, 89 Or 140 (1987)-----401,476
Miville v. SAIF, 76 Or App 603 (1985)------52
Mobley v. SAIF, 58 Or App 394 (1982)------419
Moe v. Ceiling Systems, 44 Or App 429 (1980)------271,577
Morris v. Denny's, 50 Or App 533 (1981)------624
Neely v. SAIF, 43 Or App 319 (1979)-----259

CITATIONS TO COURT CASES

COURT CASE----------PAGE(S)

Nelson v. EBI, 296 Or 246 (1984)------568
Nicholson v. Blachly, 86 Or App 645 (1987)------693
Nollen v. SAIF, 23 Or App 420 (1975)------336,363,376,465,466,489,511
Noffsinger v. Yoncalla Timber Products, 88 Or App 118 (1987)------239
North Clackamas School District v. White, 85 Or App 560 (1987)-----28
North Clackamas School Dist. v. White, 305 Or 48, 468 (1988)-----476,596
Norwest Presbyterian Incommunity Hosp., 293 Or 543 (1982)------662
Ohlig v. FMC Marine/Rail Equip. Div., 291 Or 586 (1981)------521,689
O'Neal v. Sisters of Providence, 22 Or App 9 (1975)------458,580
Parmer v. Plaid Pantry #54, 76 Or App 405 (1985)-----114,370
Perkins v. Willamette Industries, 273 Or 556 (1975)------255
Peterson v. State Farm Ins., 238 Or 106 (1964)------662
Petshow v. Farm Bureau Ins., 76 Or App 563 (1985)------276,608
Petshow v. Portland Bottling, 62 Or App 614 (1983)------92
Phil Livesley Co. v. Russ, 296 Or 25 (1983)------241
Piwowar v. Georgia Pacific, 305 Or 494 (1988)-----521
Pooschke v. U.P. Railroad, 246 Or 633 (1967)------244
Price v. SAIF, 73 Or App 123 (1985)------518
Price v. SAIF, 296 Or 311 (1984)------25,57,66,376,397,521
Proctor v. SAIF, 68 Or App 333 (1984)------476
Progress Quarries v. Vaandering, 80 Or App 160 (1986)------545
R.A. Gray & Co. v. McKenzie, 57 Or App 426 (1982)------259
Reed v. Del Chemical Corp., 40 Or App 599 (1979)------284
Reinan v. Pacific Motor Trucking Co., 270 Or 208 (1974)------662
Retchless v. Laurelhurst Thriftway, 72 Or App 728 (1985)-----110
Richmond v. SAIF, 85 Or App 444 (1987)------119
Ring v. Paper Distribution Services, 90 Or App 148 (1988)------547
Robinson v. Omark Industries, 46 Or App 263 (1980)------234
Robinson v. SAIF, 69 Or App 534 (1984)------580
Robinson v. SAIF, 78 Or App 581 (1986)------589
Rogers v. Tri-Met, 75 Or App 470 (1985)------230
Roller v. Weyerhaeuser, 67 Or App 583 (1984)-----481,596
Runft v. SAIF, 303 Or 493 (1987)-------35,261
Russell v. A & D Terminals, 50 Or App 27 (1981)------51
Safstrom v. Riedel International, 65 Or App 728 (1983)-----481
Sahnow v. Fireman's Fund Ins., 260 Or 564 (1971)------701
SAIF v. Anlauf, 52 Or App 115 (1981)-----506
SAIF v. Baer, 61 Or App 335 (1983)------246,391
SAIF v. Belcher, 71 Or App 502 (1984)------5,565
SAIF v. Brannon, 62 Or App 768 (1983)------647
SAIF v. Carey, 63 Or App 68 (1983)-----545
SAIF v. Cowart, 65 Or App 733 (1983)------655
SAIF v. Culwell, 65 Or App 332 (1983)------647,683
SAIF v. D'Lyn, 74 Or App 64 (1985)------80
SAIF v. Gygi, 55 Or App 570 (1982)------411
SAIF v. Maddox, 295 Or 448 (1983)------239,674
SAIF v. Phipps, 85 Or App 436 (1987)------608
SAIF v. Varner, 89 Or App 421 (1988)------606
Saiville v. EBI, 81 Or App 469 (1986)------41,82
Sarantis v. Sheraton Corp., 69 Or App 575 (1984)------568
Saxton v. SAIF, 80 Or App 631 (1986)------327

CITATIONS TO COURT CASES

COURT CASE----------PAGE(S)

Schlecht v. SAIF, 60 Or App 449 (1982)------31,361
Schuening v. J.R. Simplot Co., 84 Or App 622 (1987)------26,230,267,329, 355
Seibel v. Liberty Homes, 305 Or 362 (1988)-------662
Selman v. Shirley, 161 Or 582 (1939)------662
Shaw v. Portland Laundry/Dry Cleaning, 47 Or App 1041 (1980)-----440
Short v. SAIF, 79 Or App 423 (1986)------689
Short v. SAIF, 88 Or App 226 (1987)------689
Short v. SAIF, 305 Or 541 (1988)------683
Shoulders v. SAIF, 300 Or 606 (1986)------239,683,689
Silsby v. SAIF, 39 Or App 555 (1979)------264
Skinner v. SAIF, 66 Or App 467 (1984)------564
Smith v. Amalgamated Sugar, 25 Or App 243 (1976)------689
Smith v. Ed's Pancake House, 27 Or App 361 (1976)------421,631
Smith v. Ridgepine, Inc., 88 Or App 147 (1987)------70,349
Smith v. SAIF, 302 Or 396 (1986)------5,35,77,115,246,572,624,649
Somers v. SAIF, 77 Or App 259 (1986)-----115,369,430,458,486,524,547,580, 599
Southwest Forest Industries v. Anders, 299 Or 205 (1985)------674
Spivey v. SAIF, 79 Or App 568 (1986)------59,231,476
Springfield Education Assn. v. School Dist., 290 Or 217 (1980)-----616
Spurlock v. International Paper, 89 Or App 461 (1988)------110,421
Staack v. Santiam Memorial Hosp., 86 Or App 290 (1987)------65
State v. Ratliff, 304 Or 254 (1987)------284
State ex rel Huntington v. Sulmonetti, 276 Or 967 (1976)------284
State ex rel Thomas v. Hoss, 143 Or 41 (1933)------616
State Farm Fire & Casualty v. Reuter, 299 Or 155 (1985)-----284
Stepp v. SAIF, 78 Or 438 (1986)------115,423,442
Stepp v. SAIF, 304 Or 375 (1987)------624
Stevens v. Champion International, 44 Or App 587 (1980)------77
Stovall v. Sally Salmon Seafood, 84 Or App 612 (1987)------545,701
Straube v. Larson, 73 Or App 501 (1985)------117
Sykes v. Weyerhaeuser, 90 Or App 41 (1988)-----649
Sugura v. McLaughlin, 79 Or App 69 (1986)------234
Sullivan v. Banister Pipeline AM, 86 Or App 334 (1987)------42
Summit v. Weyerhaeuser, 25 Or App 851 (1976)------486
Syphers v. K-W Logging, 51 Or App 769 (1981)------468
Taaffe v. SAIF, 77 Or App 492 (1986)------547
Taylor v. Baker, 279 Or 139 (1977)------284
Taylor v. SAIF, 75 Or App 583 (1985)------58
Tiedeman v. Radiation Therapy Consultants, 71 Or App 668 (1985)-----653
Timberline Equipment v. St. Paul Fire/Marine Ins., 281 Or 639 (1978)----662
Tracy v. Lane County, 305 (1988)------693
Transpacific Leasing v. Klineline Sand, 272 Or 133 (1975)------644
United Engine Parts v. Reid, 283 Or 421 (1978)------662
United Medical Laboratories v. Bohnke, 81 Or App 144 (1986)------4
Uris v. Compensation Dept., 247 Or 420 (1967)------411,414,418,458,524,551, 580,589
Utrera v. Dept. of General Services, 89 Or App 114 (1987)-----345,355,524
Valtinson v. SAIF, 56 Or App 184 (1982)------458,580,602

CITATIONS TO COURT CASES

COURT CASE----------PAGE(S)

Van Blokland v. Oregon Health Sciences Univ., 87 Or App 694 (1987)------39, 58,65,250,458,572
Vandehey v. Pumilite Glass & Building, 35 Or App 187 (1978)------689
Van Horn v. Jerry Jerzel, Inc., 66 Or App 457 (1984)------572
Van Woesik v. Pacific Coca-Cola, 85 Or App 9 (1987)------77,425,427
Varner v. SAIF, 89 Or App 421 (1988)------580
Vester v. Diamond Lumber, 21 Or App 587 (1975)-----572
VIP's Restaurant v. Krause, 89 Or App 214 (1988)------622
Volk v. SAIF, 73 Or App 643 (1985)------246,481,502,518
Wattenbarger v. Boise Cascade, 301 Or 12 (1986)------683,689
Waxwing Cedar Products v. Koennecke, 278 Or 603 (1977)-----284
Webb v. SAIF, 83 Or App 386 (1987)------5,349,476
Weiland v. SAIF, 64 Or App 810 (1983)------5,26,87,345,368,378,429,430,438, 516,547,580,599
Weiland v. SAIF, 74 Or App 317 (1985)------474
Weller v. Union Carbide, 288 Or 27 (1979)-----250,253,257,271,281,411,418, 458,580,589
Wells v. Pete Walker's Auto Body, 86 Or App 739 (1987)------274,398
West v. SAIF, 74 Or App 317 (1985)------5,87,124,438,528,565,572
Wetzel v. Goodwin Bros., 50 Or App 101 (1981)------345,474,528
Weyerhaeuser Co. v. Miller, 88 Or App 286 (1987)------696
Weyerhaeuser Co. v. Miller, 306 Or 1 (1988)-------700
Weyerhaeuser v. Rees, 85 Or App 325 (1987)------556
Wheeler v. Boise Cascade, 298 Or 452 (1985)------411,458,589
Whipple v. Howser, 291 Or 475 (1981)------255,537,586,616
Wick v. SAIF, 37 Or App 285 (1978)------616
Wiggins v. Barrett & Associates, 295 Or 679 (1983)------701
Wights v. Staff Jennings, 241 Or 301 (1965)------662
Wilkerson v. Davila, 88 Or App 298 (1987)------385,524
Williams v. Gates, McDonald & Co., 300 Or 278 (1985)------12,15,17,20,551, 572
Williams v. SAIF, 31 Or App 1301 (1977)-----568
Wilson v. Weyerhaeuser, 30 Or App 403 (1977)------440,513
Wimer v. Miller, 235 Or 25 (1963)-----693
Winn v. Gilroy, 296 Or 718 (1984)------662
Wisherd v. Paul Koch Volkswagen, 28 Or App 513 (1977)-----291
Wood v. SAIF, 30 Or App 1103 (1977)------551
Woody v. Waibel, 276 Or 189 (1976)------234
Younger v. City of Portland, 305 Or 346 (1988)------635
Zurich Ins. v. Diversified Risk Management, 300 Or 47 (1985)-----227

REFERENCES TO CASES IN VAN NATTA'S

CASE NAME----------PAGE(S)

Richard K. Adams, 38 Van Natta 530 (1986)------486
Marco Aguiar, 38 Van Natta 413 (1986)------58,85
Danny R. Akers, 39 Van Natta 732 (1987)-------105
Patricia M. Anderson, 36 Van Natta 588 (1984)-----353
Wilma K. Anglin, 39 Van Natta 73 (1987)------70
Isabel Aparicio, 38 Van Natta 421 (1986)------391
Mason L. Asbury, 38 Van Natta 961 (1986)------110
Leland O. Bales, 38 Van Natta 25 (1986)------75,393,608
Faye L. Ballweber, 36 Van Natta 303 (1984)------5
Michael D. Barlow, 38 Van Natta 196 (1986)------572
Charles D. Barney, 39 Van Natta 646 (1987)------72,73,397
Karen J. Bates, 39 Van Natta 42 (1987)------35
George Bedsaul, 35 Van Natta 695 (1983)------68,381
Berlie O. Bold, 34 Van Natta 244 (1982)-----502
Sharon Bracke, 36 Van Natta 1245 (1984)-----239
Eldon Britt, 32 Van Natta 141 (1981)------41
Judy A. Britton, 37 Van Natta 1262 (1985)-----90,114,397,568
Michael J. Bruno, 38 Van Natta 1019 (1986)------326
Daniel J. Cannon, 35 Van Natta 1181 (1983)-----398
Robert Casperson, 38 Van Natta 420 (1986)------336,363,376,471,489,511
Ronald D. Chaffee, 39 Van Natta 1135 (1987)------26
Kenneth E. Choquette, 37 Van Natta 927 (1985)-----390
Rob Cohen, 39 Van Natta 649 (1987)------59,401
Donald W. Courtier, 39 Van Natta 705 (1987)------502
Leon E. Cowart, 40 Van Natta 22 (1988)------114
Patricia M. Dees, 35 Van Natta 120 (1983)------117
Richard M. Deskins, 38 Van Natta 494 (1986)------481
Robert G. Ebbert, 40 Van Natta 67 (1988)------465
Lloyd L. Eddings, 38 Van Natta 1478 (1986)------425
John K. Eder, 38 Van Natta 1372 (1986)------370
Billy J. Eubanks, 35 Van Natta 135 (1983)------554
John T. Elicker, 40 Van Natta 68 (1988)------381,413
Rebecca J. Ferolin, 39 Van Natta 754 (1987)------596
Deryl E. Fisher, 38 Van Natta 982 (1986)------67
Lloyd O. Fisher, 39 Van Natta 5 (1987)-----481,518
Michael D. Flannery, 39 Van Natta 723 (1987)------5
David L. Fleming, 38 Van Natta 1321 (1986)------26,58
John D. Francisco, 39 Van Natta 332 (1987)------363,376,489
Jill M. Gabriel, 35 Van Natta 1224 (1983)------1,433,575
Robert T. Gerlach, 36 Van Natta 293 (1984)------31,45,361
William J. Hamilton, 36 Van Natta 576 (1984)-----366
Thomas E. Harlow, 38 Van Natta 1406 (1986)------117
Dan W. Hedrick, 38 Van Natta 208 (1986)------26,336
Leonard Henderson, 40 Van Natta 31 (1988)------45,361
Gerald Herrington, 35 Van Natta 859 (1983)------31,361,366,381
Candy J. Hess, 37 Van Natta 12 (1985)------331
Rose Hestkind, 35 Van Natta 250 (1983)------34,108
Ronald G. Hill, 37 Van Natta 14 (1985)------476
Delbert R. Hutchinson, 39 Van Natta 32 (1987)------38
Zeno T. Idzerda, 38 Van Natta 428 (1986)------25,57,66
Harris E. Jackson, 35 Van Natta 1674 (1983)------57,66

REFERENCES TO CASES IN VAN NATTA'S

CASE NAME----------PAGE(S)

Robert C. Jaques, 39 Van Natta 299 (1987)------363,376,466,489
Alexander M. Johnson, 38 Van Natta 1313 (1986)------518
James M. Kleffner, 38 Van Natta 1413 (1986)------602
George J. Kovarik, 38 Van Natta 1381 (1986)------92
Charlotte Kuklhanek, 37 Van Natta 1697 (1985)------373
Dianna Lawton, 38 Van Natta 1543 (1986)------433
Jimmy C. Lay, 37 Van Natta 583 (1985)------110
Natasha D. Lenhart, 38 Van Natta 1496 (1986)------34,108,488
Kathryn I. Looney, 39 Van Natta 1140 (1987)------108,488
Delfina P. Lopez, 37 Van Natta 164 (1985)------75,90,91,338,397,551
Julio P. Lopez, 38 Van Natta 862 (1986)------63,67,335,337,343,371,443,594
Steven B. Lubitz, 39 Van Natta 809 (1987)------34,108,488
Robert E. Lundeen, 38 Van Natta 1388 (1986)------374,384
David Martin, 39 Van Natta 447 (1987)------331
Ronald L. McMahill, 39 Van Natta 399 (1987)------468
Maria C. Mendoza, 40 Van Natta 499 (1988)------595
Virginia Merrill, 35 Van Natta 251 (1983)------34,108,488
Rita Mitchell, 39 Van Natta 436 (1987)------73,77
Alberto V. Monaco, 39 Van Natta 337 (1987)------52
Robert T. Moon, 39 Van Natta 370 (1987)------41
Joyce A. Morgan, 36 Van Natta 114 (1984)------96
Janelle I. Neal, 40 Van Natta 359 (1988)-----531,555
John J. O'Halloran, 34 Van Natta 1504 (1982)------68,381
Bernard L. Osborn, 37 Van Natta 1054 (1985)------44,106,393,505,532,568,609
Donald L. Oxford, 38 Van Natta 1297 (1986)------411
Robert G. Perkins, 36 Van Natta 1050 (1984)------331
Alfred F. Puglisi, 39 Van Natta 310 (1987)------63,67,335,337,343,371,443,594
Mark L. Queener, 38 Van Natta 882 (1986)------53
Debra A. Reese, 38 Van Natta 101 (1986)------502
Myron W. Rencehausen, 39 Van Natta 56 (1987)------326
Joseph A. Reznicsek, 36 Van Natta 1361 (1984)------602
Chester R. Rhodes, 38 Van Natta 1396 (1986)------476
Roger Riepe, 37 Van Natta 3 (1985)------366
Marlene W. Ritchie, 37 Van Natta 1088 (1985)------401
Charles W. Roller, 39 Van Natta 504 (1987)------572
James L. Sampson, 37 Van Natta 1549 (1985)-----363,376,489
Mario Scarino, 39 Van Natta 663 (1987)------102,339
Nancy J. Schelin, 39 Van Natta 437 (1987)------343,371
Leroy R. Schlecht, 32 Van Natta 261 (1981)------31,361
Brian J. Shaw, 39 Van Natta 438 (1987)-----353
Clay B. Sheppard, 39 Van Natta 125 (1987)------59
Roger A. Shoff, 38 Van Natta 163 (1986)------683
Andrew Simer, 37 Van Natta 118 (1985)------486
David E. Sitton, 36 Van Natta 773 (1984)------577
Karola Smith, 38 Van Natta 76 (1986)------117
Gary O. Soderstrom, 35 Van Natta 1710 (1983)------387
Fred C. Spivey, 38 Van Natta 1033 (1986)------38
Eva L. (Doner) Staley, 38 Van Natta 1280 (1986)------414
Ramona Steckmann, 40 Van Natta 90 (1988)------551

REFERENCES TO CASES IN VAN NATTA'S

CASE NAME----------PAGE(S)

Rodney C. Strauss, 37 Van Natta 1212 (1985)------75,393,608
Timothy J. Swodeck, 39 Van Natta 341 (1987)------390,427
Ernest E. Thompson, 39 Van Natta 455 (1987)------577
Mickey A. Thresher, 39 Van Natta 456 (1987)------481
Karen K. Vansanten, 40 Van Natta 63 (1988)------465
Susan Vernon, 37 Van Natta 1562 (1985)------338
Wayne A. Volk, 36 Van Natta 1083 (1984)-----502
Nick L. Ward, 34 Van Natta 1739 (1984)------561
David F. Welch, 39 Van Natta 468 (1987)------602
Barbara A. Wheeler, 37 Van Natta 122 (1985)------38,70,390,470
James D. Whitney, 37 Van Natta 1463 (1985)------4,129,351,500,540
Robert B. Williams, 37 Van Natta 711 (1985)------68,381
Robert B. Williams, 38 Van Natta 119 (1986)------366,450
Richard L. Wine, 39 Van Natta 49 (1987)------92
Alvin L. Woodruff, 39 Van Natta 1161 (1987)------67
Jose Ybarra, 40 Van Natta 5 (1988)------565

CITATIONS TO OREGON REVISED STATUTES

STATUTE	PAGE(S)
ORS 8.310	122
ORS 18.160	22
ORS 18.580	662
ORS 19.028	696
ORS 19.029	122
ORS 19.078	122
ORS 30.020	102,339
ORS 30.030(2)	102,339
ORS 30.040	102,399
ORS 33.010	122
ORS 43.130	284
ORS 87.001	696
ORS 87.018	696
ORS 87.060	696
ORS 87.075	696
ORS 87.093	696
ORS 138.185	122
ORS 147.005 to 147.365	1,433,575
ORS 147.005(4)	433
ORS 147.015	433
ORS 147.015(1)	433
ORS 147.015(4)	1
ORS 147.015(6)(a) & (b)	575
ORS 147.155(5)	1,400,433,575
ORS 147.365	575
ORS 161.085(7)	433
ORS 161.085(8)	433
ORS 161.085(9)	433
ORS 174.010	683
ORS 174.120	93,100,105,109,335,378,443,466
ORS 183.310 to 183.550	268,387
ORS 183.341	696
ORS 183.470(2)	616
ORS 183.480(1)	387
ORS 183.480(2)	387
ORS 183.482(1)	387
ORS 183.482(7)	616,635
ORS 183.482(8)	616,635
ORS 183.482(8)(c)	616
ORS 411.590	236
ORS 656.003	291
ORS 656.005	291
ORS 656.005(2)	655
ORS 656.005(3)	102,339
ORS 656.005(5)	655
ORS 656.005(7)(b)	674
ORS 656.005(7)(c)	674
ORS 656.005(8)	281,291,425
ORS 656.005(8)(a)	281,524,580
ORS 656.005(8)(b)	349
ORS 656.005(8)(c)	281

CITATIONS TO OREGON REVISED STATUTES

STATUTE----------PAGE(S)

ORS 656.005(9)----------419
ORS 656.005(10)----------373
ORS 656.005(13)----------234,502
ORS 656.005(17)----------26,228,329,524
ORS 656.005(19)----------63,336,363,374,376,471,489,511,536
ORS 656.005(26)----------568
ORS 656.005(27)----------234
ORS 656.012(a)(b)(c)----------70
ORS 656.017----------234
ORS 656.017(1)----------234
ORS 656.018----------234,693
ORS 656.018(1)(a)----------693
ORS 656.018(2)----------693
ORS 656.018(3)----------693
ORS 656.027(1)----------236
ORS 656.027(7) et seq.----------80
ORS 656.027(9)----------80
ORS 656.039(4)----------80
ORS 656.128----------80
ORS 656.154----------45,102,339,693
ORS 656.156(1)----------481
ORS 656.202 to .258----------419
ORS 656.202----------616
ORS 656.202(2)----------506,537,586
ORS 656.204(1)----------373
ORS 656.204(2), (4) & (5)--------373
ORS 656.206----------633
ORS 656.206(1)----------440
ORS 656.206(1)(a)----------513,556
ORS 656.206(3)----------49,624
ORS 656.210(1)----------246,568,602,649
ORS 656.210(2)----------41,568,602
ORS 656.210(2)(b)(B)----------620
ORS 656.210(3)----------638
ORS 656.210(4)----------246
ORS 656.212----------398
ORS 656.214(2)----------391,429,453,514,577
ORS 656.214(5)----------26,58,378,383,389,429,453,513,556,562,
568,577
ORS 656.216(1)----------674
ORS 656.218(5)----------373
ORS 656.236----------278,366,493
ORS 656.236(1)----------119,366,493,701
ORS 656.236(2)----------255
ORS 656.245----------11,31,101,250,284,438,474,510,628
ORS 656.245(1)----------8,39,53,58,87,124,345,430,524,528,572,
599,638
ORS 656.245(2)----------425
ORS 656.262----------291,374,521
ORS 656.262(2)----------228,291,674
ORS 656.262(4)----------59,264,291

CITAITONS TO OREGON REVISED STATUTES

STATUTE----------PAGE(S)

ORS 656.262(6)----------22,59,96,284,291,401,521,554,674
ORS 656.262(9)----------281,284
ORS 656.262(10)----------59,70,228,231,239,264,284,291,349,401,
419,481,518,554,568,659,674
ORS 656.262(11)----------349
ORS 656.262(12)----------349
ORS 656.263----------374
ORS 656.265 to .330----------374
ORS 656.265----------532
ORS 656.265(1)----------532
ORS 656.265(4)(a)----------532,580
ORS 656.265(4)(c)----------532
ORS 656.266----------649
ORS 656.268----------268,329,481,518,622,649,674
ORS 656.268(1)----------8,268,481,524
ORS 656.268(2)----------5,8,239,481,502,518
ORS 656.268(2)(c)----------502
ORS 656.268(3)----------8,246,349,476,518
ORS 656.268(4)----------5,674
ORS 656.268(5)----------5
ORS 656.273 to 656.278----------31,68
ORS 656.273----------56,349,361,403,481,636,638
ORS 656.273(1)----------35,77,425,468,547,572,624
ORS 656.273(2)----------358
ORS 656.273(3)----------77,358
ORS 656.273(4)----------358
ORS 656.273(4)(a)----------53,468
ORS 656.273(4)(b)----------70,349,476
ORS 656.273(6)----------264,358
ORS 656.278----------52,64,74,82,325,325,331,348,349,351,353,
358,358,359,361,380,437,456,457,481,509,
537,633,696
ORS 656.278(1)----------127,537,586
ORS 656.278(1)(a)----------62,62,64,70,76,83,94,94,99,325,328,329,
332,333,344,348,348,351,352,352,353,354,
354,355,356,356,358,359,360,365,437,439,
444,447,452,455,456,456,457,458,464,466,
467,473,508,508,509,509,520,532,537,537,
586,588
ORS 656.278(3)----------537,586
ORS 656.278(5)(a)----------52
ORS 656.283----------68,117,268,373,674,693
ORS 656.283(1)----------92,476
ORS 656.283(2)----------51
ORS 656.283(3)----------117
ORS 656.283(4)----------674
ORS 656.283(5)----------374
ORS 656.283(7)----------40
ORS 656.289----------616
ORS 656.289(1)----------84,370,499,536,595
ORS 656.289(2)----------374,384

CITATIONS TO OREGON REVISED STATUTES

STATUTE	PAGE(S)
ORS 656.289(3)	4,12,25,43,43,48,52,57,63,66,67,83,84, 100,105,105,109,259,335,336,337,343,363, 365,370,371,374,376,381,443,465,466,471, 472,489,499,511,536,594,595,683,689,696
ORS 656.289(4)	278,291,476,493
ORS 656.295	43,43,48,63,67,84,109,268,326,335,336, 337,343,363,365,370,371,376,408,443,465, 466,471,472,489,499,511,536,594,595,616, 683,689
ORS 656.295(1)	72,105
ORS 656.295(2)	43,43,48,63,67,83,100,105,109,335,336, 337,343,363,365,370,371,376,408,443,465, 466,471,472,489,511,536,594,696
ORS 656.295(3)	25,58,121,123,333,334,545
ORS 656.295(5)	4,25,26,40,67,74,75,90,91,96,106,118, 121,123,333,334,338,373,385,393,396,397, 403,505,532,545,551,568,580,606,609
ORS 656.295(6)	616
ORS 656.295(8)	12,98,109,115,342,381
ORS 656.298	480;635
ORS 656.298(3)	227,281,616,696
ORS 656.298(6)	616,629,701
ORS 656.307	53,226,276,325,359,437,467,509,608,622
ORS 656.307(1)(b)	359,467
ORS 656.307(5)	276
ORS 656.310(2)	271
ORS 656.313	659,674
ORS 656.313(1)	291,659,674,696
ORS 656.313(2)	674
ORS 656.313(3)	278,291
ORS 656.313(4)	92,291,674
ORS 656.319	117,228,476
ORS 656.319(1)(b)	22
ORS 656.319(4)	423,442
ORS 656.325(1)	280
ORS 656.340	622,693
ORS 656.382 to .388	374
ORS 656.382	85,231,425,481,683
ORS 656.382(1)	70,231,239,291,401,419,425,476,568,674
ORS 656.382(2)	72,73,73,77,121,231,239,327,345,347,378, 395,397,407,414,419,425470,474,479,481, 492,501,520,521,539,543,608,683,688,689
ORS 656.382(3)	683
ORS 656.386	683,689
ORS 656.386(1)	53,85,121,239,353,425,458,506,528,568, 683,688,689
ORS 656.388	647,683,689
ORS 656.388(1)	85,366,407,521
ORS 656.388(2)	506,647,683,689
ORS 656.440(2)	696
ORS 656.560(2)	696
ORS 656.576 et seq.	366

CITATIONS TO OREGON REVISED STATUTES

STATUTE	PAGE(S)
ORS 656.576 to 656.595	45
ORS 656.578	45,102,339,381,450,495
ORS 656.580(1)	655
ORS 656.580(2)	102,339,450,655
ORS 656.583	495,593
ORS 656.583(1)	495,696
ORS 656.583(2)	495
ORS 656.587	34,68,108,366,488,655
ORS 656.591	495,655
ORS 656.591(1)	102,339,495
ORS 656.591(2)	102,339,495
ORS 656.593	45,339,381,495,655
ORS 656.593(1)	34,68,102,108,339,366,450,488,491,495,655
ORS 656.593(1)(a)	31,68,361,366,450,495
ORS 656.593(1)(b)	31,45,68,102,339,361,366,450,495,593
ORS 656.593(1)(c)	31,68,361,366,381,450,495
ORS 656.593(1)(d)	31,102,339,366,381,413,450,495
ORS 656.593(2)	68,102,339,361
ORS 656.593(3)	31,68,102,339,361,366,381,450
ORS 656.625	56,62,64,74,325,325,329,332,333,354,356, 358,360,437,439,447,456,464,473,508,509, 537,586,588
ORS 656.625(1)	537,586
ORS 656.625(2)	537,586
ORS 656.704(1)	693
ORS 656.704(2)	268
ORS 656.708	693
ORS 656.726(4)	696
ORS 656.728(3)	268
ORS 656.728(6)	268
ORS 656.802 to 656.824	281
ORS 656.802	281
ORS 656.802(1)(a)	271,447,458,558,580,589
ORS 656.804	281,562,701
ORS 656.806	701
ORS 656.807(1)	403,580
ORS 656.990(1)	701
ORS 659 et seq.	521
ORS 656.121	644
ORS 656.121(2)	644
ORS 659.410	614,644
ORS 659.415	614,644
ORS 659.415(1)	614
ORS 659.425	701
ORS 731.162	278,291
ORS 806.010	433
ORS 811.135	433
ORS 811.182	433

ADMINISTRATIVE RULE CITATIONS

RULE----------PAGE(S)

OAR 137-76-010(3)----------1
OAR 137-76-030(1) & (2)----------575
OAR 436-10-040(1)(a)----------474
OAR 436-10-040(2)(a)----------554
OAR 436-10-060(2)----------502,565
OAR 436-10-070----------70
OAR 436-10-070(2)----------70
OAR 436-10-070(3)(a)----------70
OAR 436-10-090(5)----------387
OAR 436-10-090(6)(a)----------387
OAR 436-10-110(5)----------387
OAR 436-10-110(5)(a)----------387
OAR 436-30-005----------674
OAR 436-30-005(4)----------391
OAR 436-30-010----------674
OAR 436-30-230(4)----------391
OAR 436-30-300----------391
OAR 436-30-320----------391
OAR 436-30-330----------429,453
OAR 436-30-340----------429,453
OAR 436-30-340(2)----------391
OAR 436-30-340(5)----------391
OAR 436-30-350----------391
OAR 436-30-380 et seq.----------30,49,124,378,383,385,389,453,513,556,568
OAR 436-30-490(2)(a)----------246
OAR 436-45-000 et seq.----------74,325,325,329,332,333,354,356,358,360,
437,439,447,456,464,473,508,509,588
OAR 436-54-212----------620
OAR 436-60-020----------620
OAR 436-60-020(4) et seq.----------41
OAR 436-60-020(4)(a)----------568,620
OAR 436-60-020(4)(c)----------41,620
OAR 436-60-020(4)(i)----------568
OAR 436-60-020(4)(J)----------568
OAR 436-60-030----------398
OAR 436-60-040(3)----------5
OAR 436-60-050(4)----------474
OAR 436-60-090----------280
OAR 436-60-140----------521
OAR 436-60-150(5)----------92
OAR 436-60-150(5)(a)----------674
OAR 436-60-180----------226,325,359,437,467,509
OAR 436-60-180(3)----------622
OAR 436-60-180(14)----------467
OAR 436-61-100----------268
OAR 436-61-400----------268
OAR 436-61-430(5)----------268
OAR 436-61-998----------268
OAR 436-69-401(2)----------565
OAR 436-120-230(4)----------5
OAR 436-120-250(7) & (8)----------268

ADMINISTRATIVE RULE CITATIONS

RULE----------PAGE(S)

OAR 438-05-040(4)----------4,105
OAR 438-05-040(4)(b)----------696
OAR 438-05-040(4)(c)----------105
OAR 438-05-046----------93
OAR 438-05-046(1)(a)----------83,540
OAR 438-05-046(1)(b)----------43,43,48,83,100,109,335,337,349,357,408,
466,540
OAR 438-05-046(2)(b)----------363,471,489,511
OAR 438-06-085----------280
OAR 438-07-005(3)----------338
OAR 438-07-005(3)(b)----------40
OAR 438-07-005(5)----------338
OAR 438-07-015----------22
OAR 438-07-015(2)----------59,106,393,532
OAR 438-09-010----------493
OAR 438-11-005----------696
OAR 438-11-005(2)----------4,105,696
OAR 438-11-005(3)----------363,471,489,511
OAR 438-11-020(1)----------72
OAR 438-11-035(2)----------602
OAR 438-12-032(3)----------325,359,437,467,509,509
OAR 438-12-052(2)----------62,62,64,70,76,82,83,94,94,99,122,325,
329,332,333,444,458
OAR 438-12-052(2)(c)----------56
OAR 438-12-052(3)----------56
OAR 438-12-055----------56,62,64,74,122,325,329,332,333,354,358,
360,439,447,456,464,473,508,588
OAR 438-15-001----------359,531,555
OAR 438-15-005(2)----------345,347,378,407,414,425,458,474,476,479,
481,492,520,528,539,543,608
OAR 438-15-005(4)----------359,531,555
OAR 438-15-005(5)----------359,407,531,555
OAR 438-15-005(7)----------359,531,555
OAR 438-15-010(1)----------101,378,430
OAR 438-15-010(5)----------328,345,347,359,378,395,407,414,425,430,
458,474,476,479,492,515,520,521,528,531,
539,543,555,596
OAR 438-15-010(6)----------42,75,85,94,95,95,95,96,98,98,99,102,106,
121,327,328,332,345,353,356,359,371,390,
393,446,470,481,491,491,501,511,515,516,
521,531,554
OAR 438-15-015----------366
OAR 438-15-020(2)----------515
OAR 438-15-027----------395
OAR 438-15-050----------493
OAR 438-15-060(1)----------85
OAR 438-15-070----------73,395,470,481,501
OAR 438-15-085(2)----------127
OAR 438-15-095----------366
OAR 438-47-010----------72,397
OAR 438-47-010(2)----------606,683

ADMINISTRATIVE RULE CITATIONS

RULE	PAGE(S)
OAR 438-47-015	606,683
OAR 438-47-020(1)(a)	53,481
OAR 438-47-020(1)(b)	481
OAR 438-47-030(1)	481
OAR 438-47-045(1)	85
OAR 438-82-025	400
OAR 438-82-030(2)	1,433,575

LARSON CITATIONS

LARSON	PAGE(S)
1 Larson, Workmen's Compensation Law, Section 13.21 at 3-415 (1985)	12,15,17,20
1A Larson, WCL, Section 41.31 (1973)	458
1B Larson, WCL, Sections 37.20, 38.83 (f) (1987)	458
1B Larson, WCL, Section 39.20 (1987)	458
1C Larson, WCL 8-284, Section 47.00 (1986)	701
1C Larson, WCL. Section 47.53 (1986)	701
3 Larson, WCL, Section 79.72(a) & n26 (1983)	284
4 Larson, WCL, Section 95.00-95.21 (1983)	701

OREGON EVIDENCE CODE CITATIONS

	Page
OEC 201(b)	271
OEC 403	244
OEC 702	653

OREGON RULES OF CIVIL PROCEDURE CITATIONS

Rule	Page(s)
ORCP 21	693
ORCP 47E	653

The following Memorandum Opinions are not published in this volume. These decisions may be ordered from the Workers' Compensation Board using the numbers provided.

MEMORANDUM OPINIONS 1988

Name, WCB Number (Month/Year)

Arendt, Elizabeth J., 85-15328 (4/88)
Avery, Michael D., 86-11463 (4/88)
Baker, Carolyn M., 86-12447 (5/88)
Barr, Charles E., 85-10536 (1,1/88)
Bell, Henry C., 85-07343 (6/88)
Bennett, Charles L., 86-14862 (3/88)
Bennett, Ronald E., 86-00466 (3/88)
Bice, Carlos D., 86-15365 (4/88)
Brown, Walter L., 86-00239 etc. (3/88)
Brummett, Bryce D., 86-06567 (2/88)
Burbank, Virginia A., 86-06381 (1/88)
Campbell, Roberta C., 86-08240 (6/88)
Carpenter, Phillip, 86-03489 (3/88)
Carroll, Ruth, 86-00074 (1/88)
Carter, James R., 86-17612 etc. (2,3/88)
Caruso, Lynne M., 87-11799 (4/88)
Chase, Donald D., 85-13588 etc. (1/88)
Chavez, Rudy F., 86-11115 (3/88)
Cheney, James R., 86-00195 (1,2/88)
Christianson, Becky, 87-05005 etc. (6/88)
Clevenger, Lois M., 86-11511 etc. (6/88)
Conn, Ronald E., 87-01587 (6/88)
Coolbaugh, Karen, 86-07792 (2/88)
Cooper, Malissa K., 86-09048 (2/88)
Cox, Kenneth E., 85-06935 (1/88)
Crooms, William K., 87-04456 (6/88)
Culora, Vincent, 87-02349 (6/88)
Davis, Delbert G., 86-09371 (1,1,3/88)
Dean, Daren H., 86-08300 (2/88)
Delanoy, Conrad N., 86-11549 (2/88)
Doak, Wade A., 86-09423 (2/88)
Doran, Ron A., 86-08874 (4/88)
Dumas, Marian S., 86-08169 (1/88)
Dunfee, Charles P., 86-17706 (1/88)
Dye, James L., 86-11183 (3/88)
Easterday, Richard W., 86-08893 (2/88)
Esparza, Abel V., 86-13614 etc. (3,4/88)
Evans, Hubert E., 87-00647 (3/88)
Finch, Carolyn L., 86-17443 (2/88)
Fisher, Debra, 86-09793 (2/88)
Fisher, Edward D., 87-00696 (3/88)
Fogerson, Harold W., 87-09582 (5/88)
Gaines, Rodger L., 86-08172 etc. (2/88)
Gander, Randall C., 86-03814 etc. (1/88)
Garcia, Manuel, 86-07831 etc. (2/88)
Garland, Roger J., 86-11736 (1/88)
Gaspard, Joy, 83-03648 (1/88)
Gilbertson, Stanley V., 86-18000 (1/88)
Gilmore, Pamela M., 86-07019 (1,1/88)
Ginn, Walter E., 86-11393 (3/88)
Golden, Gerald A., 85-01678 etc. (1/88)
Goodwin, Robert M., 86-11081 (1/88)
Gordon, Dennis/Debra (2/88)
Gove, Donna L., 86-14859 (1/88)
Grigsby, Beverly, 86-02771 (3/88)
Gum, Harold L., 86-03997 (1/88)
Gutierrez, Antonio, 86-10589 (1/88)
Heisler, Bonnie A., 86-10481 (3/88)
Hileman, Bette J., 86-14955 (2/88)
Hollenbeck, Tom, 84-06580 (1/88)
Holliday, Anna, 86-16249 (6/88)
Hollstrom, Carl E., 85-15291 (2/88)
Hults, Robert J., 86-10732 (1/88)
Jacobs, Elmer, 86-07590 (2/88)
Janini, Robert D., 87-11480 (4/88)
Johnson, Jeff, 86-10180 (3/88)
Johnson, Pamila M., 86-06987 (3/88)
Kahl, William, 82-10923 etc. (3/88)
Kester, Clifford L., 86-08282 (1/88)
Kim, Hun J., 86-09851 (2/88)
Koon, Charlene C., 86-12176 (6/88)
Kreitzer, David A., 86-00395 (3/88)
Kutter, William A., 86-13360 (5/88)
Lamb, Donna J., 86-10576 etc. (3/88)
Langsev, Berniece, 86-05850 (1/88)
Lennon, Debra A., 86-12095 (4,5,6/88)
Lowe, Phillip E., 83-10098 (2/88)
Mametieff, Ivan C., 86-10847 (2/88)
Martin, Delores A., 86-01972 (1/88)
Martusheff, Elisey E., 86-08403 (1/88)
McElmurry, Theodore, 85-10233 (1/88)
McGhee, Michael R., 86-03314 (3/88)
Meneley, Rozana, 86-08194 (2/88)
Miller, Don D., 86-02733 etc. (2/88)
Miller, Lonnie, 86-11088 (2/88)
Mitchell, Carolyn S., 86-11739 (2/88)
Mitts, Joyce E., 86-08996 (4,5/88)
Mollgaard, Lester R., 86-07735 (3/88)
Monte, Sharon A., 86-06721 (1/88)
Moody, Eul G., 85-07649 (3,4/88)
Moore, Diann L., 86-16322 (3/88)
Moore, Judith A., 86-08191 (6/88)
Moreno, Michael J., 86-09057 (2/88)
Murphy, Carol B., 86-07762 (1/88)
Nafts, Everett J., 87-01481 (6/88)
Newton, Jack A., 85-09615 (1/88)
Niccolai, Patrick J., 86-03442 (1/88)
Nichols, David R., 86-18238 (3/88)
Nielson, Thomas, 86-12944 (1/88)

Name, WCB Number (Month/Year)

Norris, Harla J., 86-17400 (3/88)
O'Neal, Kathleen, 86-06520 (1/88)
Oseguerra, Alicia, 86-17204 (2/88)
Parsons, James I., 86-15528 (1/88)
Pirkey, John, 86-10818 (3/88)
Poole, Robert R., 87-02799 (3/88)
Rabe, Gary L., 86-06687 (1/88)
Rabinowitz, Richard N., 84-00712 (1/88)
Redford, Sherryle D., 86-16565 (1/88)
Renfro, Ronald, 87-16190 (6/88)
Resendez, Nick, 86-11974 (1/88)
Rich, Ninalouise L., 85-14229 (3/88)
Richter, Karen J., 86-08064 (3/88)
Robinson, James A., 80-10672 (1/88)
Romano, Sherry, 86-11138 etc. (1/88)
Rust, Dorothy D., 86-10074 (3/87)
Schilling, Patricia J., 87-10390 (4/88)
Schmidt, David L., 85-08866 (4/88)
Schmiedel, Dixie L., 85-06289 etc. (2/88)
Schwarzbauer, Martin J., 86-12942 (3/88)
Scott, Floyd G., 84-07857 (3/88)
Sharp, Tamera A., 87-04470 (6/88)
Shelton, Robert D., 86-11905 etc. (2/88)
Sherman, Jerry A., 86-11774 (2/88)
Shipp, Joseph R., 86-07925 (2/88)
Sierzega, Louis A., 86-08559 (1/88)
Smith, Perry D., 86-13250 (1/88)
Smith, Roger A., 86-15575 etc. (1/88)
Stanley, Jane E., 86-11196 (2/88)
Sweeden, Gloria G., 86-02493 etc. (3/88)
Taylor, Jean, 86-10380 (6/88)
Terry, Judith A., 87-07231 (6/88)
Thai, Lam M., 86-16176 (3/88)
Thayer, Timothy E., 86-07379 (1/88)
Truong, Phong Q., 86-01079 (3,4/88)
Valek, Debra J., 86-07932 etc. (3/88)
Velaquez, Victor M., 86-13734 (1/88)
Welin, Gary W.,, 86-17951 (3/88)
Wende, Adolph W., 86-16961 (2/88)
West, Sylvia M., 87-14155 (6/88)
Whitney, Michael J., 86-08779 (3/88)
Wilson, Juan R., 86-15231 (4,5/88)
Winegar, Jeffrey L., 86-09749 (1/88)
Winkler, Duane J., 86-17374 (3/88)
Wise, Gerald D., 86-06433 (2/88)
Young's Bay Restaurant, (2/88)
Young, Sherry A., 84-08119 (4/88)

The following decisions under the Board's Own Motion Jurisdiction are not published in this volume. They may be ordered from the Workers' Compensation Board using the numbers provided.

OWN MOTION JURISDICTION 1988

Name, WCB Number (Month/Year)

Abel, Kenneth, 88-0082M (3/88)
Aderton, Frances L., 87-0693M (5/88)
Allen, Merle A., 87-0253M (1/88)
Anderson, Eva, 88-0080M (3/88)
Anderson, Marion Ray, 86-0411M (2/88)
Antilla, Henry O., 88-0023M (2/88)
Armon, Lowell, 88-0197M (5/88)
Arndorfer, William, 88-0282M (5/88)
Arnold, Donovan L., 88-0149M (5/88)
Arvidson, George L., 84-0581M (4/88)
Atkinson, Kevin, 88-0054M (5/88)
Atleson, Sherri, 87-0593M (2/88)
Baldridge, Danny M., 88-0044M (3,6/88)
Baldwin, Gene F., 88-0174M (4/88)
Baney, Ruby, 88-0220M (5/88)
Barber, Milton S., 84-0438M (1/88)
Barnes, Donald R., 88-0056M (2/88)
Barton, William, 88-0200M (5/88)
Bathke, John W., 87-0660M (1,2/88)
Beckstead, James K., 87-0580M (1/88)
Bedsaul, Michael, 88-0264M (5/88)
Benda, Elden, 88-0140M (4/88)
Bennett, Joseph, 88-0019M (1/88)
Benton, James E., 87-0228M (4/88)
Berg, Alex M., 88-0005M (1/88)
Bergamo, Terry, 88-0261M (5/88)
Best, Curtis, 87-0401M (6/88)
Bettin, Clifford A., 86-0257M (3/88)
Bidney, Donald, 87-0721M (1/88)
Billups, Terry, 88-0055M (2/88)
Bilyeu, Patricia J., 87-0487M (1/88)
Black, Thomas L., Sr., 88-0007M (1/88)
Blake, Pamela R., 87-0476M (1/88)
Blaser, Martin E., 88-0159M (5/88)
Bodda, Harvey, 87-0312M (5/88)
Borisoff, Henry T., 87-0404M (1/88)
Bostwick, Harry R., 87-0657M (2/88)
Bradford, Timothy J., 87-0467M (6/88)
Brasmer, Silas F., 88-0115M (4/88)
Brenner, John, 88-0165M (4/88)
Brewer, Norman P., 88-0027M (2/88)
Brookshire, Joy J., 86-0689M (1/88)
Brown, Charles E., 86-0637M (6/88)
Brown, Donald M., 87-0718M (1/88)
Brown, Patrick B., 88-0016M (1/88)
Bruner, Michael, 88-0020M (1/88)
Buckman, Danny, 88-0353M (6/88)
Burgess, Paul H., 87-0351M (1/88)
Burrington, Kyle, 87-0711M (6/88)
Burris, Joann, 86-0382M (2,4/88)
Burt, William A., 87-0609M (1/88)
Burton, Jack, 87-0674M (1/88)
Bush, Ernest M., 87-0333M (5/88)
Bush, Shirley, 88-0109M (4/88)
Caccamise, Chris, 86-0680M (2/88)
Cambron, Connell R., 88-0034M (2/88)
Campbell, Jess P., 87-0700M (1/88)
Carlston, Lois O., 88-0342M (6/88)
Carlton, Dennis L., 88-0212M (5/88)
Carter, Donald, 88-0251M (5/88)
Castoe, Ezra E., 87-0745M (2/88)
Charlson, Lynn, 88-0278M (6/88)
Chastain, Ronald, 88-0235M (5/88)
Cheatham, Verla, 87-0534M (5/88)
Chilson, Bonnie D., 88-0120M (3/88)
Chrestensen, Robert, 88-0119M (4/88)
Christensen, Jesse D., 88-0081M (2/88)
Christopher, Ohman E., 87-0746M (1/88)
Christopher, Terry, 87-0712M (4/88)
Clark, William, 87-0760M (1/88)
Clements, Thomas, 88-0257M (5/88)
Clevenger, Shirley E., 88-0206M (5/88)
Cochran, Robert, 88-0313M (6/88)
Collins, Donna, 85-0154M (1/88)
Cook, Dalta, 88-0001M (1/88)
Cooper, Gilbert W., 88-0026M (1/88)
Copher, Edwin L., 88-0108M (4/88)
Corliss, Phillip, 87-0753M (1/88)
Cox, Charley, 88-0185M (6/88)
Craig, James, 88-0321M (6/88)
Cress, Stanley, 88-0228M (5/88)
Cripps, Donald R., 87-0755M (1/88)
Crowder, Virgie Mae, 88-0250M (5/88)
Cummins, Mary J., 88-0208M (5/88)
Curtiss, Betty, 88-0312M (6/88)
Dalton, Robert W., 88-0085M (3/88)
Danielson, James L., 87-0259M (5/88)
Darcy, James G., 86-0600M (2/88)
Davenport, John D., 88-0273M (6/88)
David Hernandez, Isabel, 88-0071M (3,3/88)
Davidson, Raymond, 88-0057M (3/88)
Davis, Frances, 87-0689M (5/88)
Davis, Wallace J., 87-0744M (4/88)
Davis, Wanda L., 88-0004M (1,2/88)
Delgado, Nicholas, 88-0039M (3/88)
Deoton, Orville, 85-0014M (1/88)
Diaz, Barbara Ann, 87-0154M (2,2/88)
Dilka, Richard, 88-0103M (3/88)
Doggett, Kenneth M., 88-0038M (2/88)
Dolinar, Henry J., 88-0122M (4/88)
Douglass, Paul, 87-0285M (6/88)
Driggers, Roger, 86-0429M (1/88)
Dubay, Kenneth L., 88-0245M (6/88)
Duncan, Robert L., 87-0670M (2,2/88)
Dupont, Ruben F., 88-0064M (2/88)
Durlam, Eugene D., 88-0031M (2/88)

OWN MOTION JURISDICTION 1988

Name, WCB Number (Month/Year)

Duyck, Richard J., 88-0182M (5/88)
Dyson, Daniel J., 88-0053M (2/88)
Eaton, Eleanor A., 87-0728M (1/88)
Edwards, Michael, 88-0033M (2/88)
Elder, William H., 88-0339M (6/88)
Elston, David, 88-0045M (4,6/88)
English, James C., 87-0160M (4/88)
Ensign, Gary, 87-0354M (1,2,4/88)
Erwen, Ted, 87-0738M (1/88)
Evison, Marjorie, 87-0531M (2/88)
Fain, Mary C., 87-0627M (1/88)
Felton, Roxy Dean, 87-0071M (3/88)
Ferber, Gwynn, 86-0417M (4/88)
Ferebee, John, 87-0208M (3/88)
Ferguson, Bill E., 87-0752M (1/88)
Fields, Eddie, 84-0536M (1/88)
Flaherty, Lawrence M., 88-0327M (6/88)
Follett, Larry L., 88-0175M (6/88)
Fowler, Sharon L., 88-0028M (2/88)
Franzwa, Peter, 88-0248M (6/88)
Frear, James, 85-0675M (3/88)
Frey, Edward, 88-0167M (4/88)
Friend, Joseph, 88-0077M (2/88)
Gabilondo, David, 87-0717M (1/88)
Garnett, Harold D., 88-0214M (5/88)
Garza, Anita, 88-0326M (6/88)
Gavett, Mark J., 87-0702M (1/88)
Geenty, Richard, 83-0313M (1/88)
Gettman, Wilbur R., 88-0294M (6/88)
Goetz, Steven, 88-0304M (5/88)
Golden, Susan L., 87-0269M (2/88)
Grant, Maxine, 87-0023M (1/88)
Greenwade, Alton W., 88-0170M (4/88)
Gregg, Robert, 88-0176M (4/88)
Gregor, Andrew J., 88-0295M (6/88)
Griffin, Terrance A., 87-0618M (5/88)
Grimm, Kenneth, 88-0329M (6/88)
Griswold, James C., 87-0756M (2/88)
Grove, Gerald, 85-0361M (3/88)
Guerra, Michael, 88-0048M (2/88)
Hafemann, Diana, 88-0178M (5/88)
Hager, Jim, 88-0287M (5/88)
Hagg, Mary J., 87-0607M (3/88)
Hagger, Danny G., 87-0639M (5/88)
Hale, Glenn, 87-0750M (1/88)
Hall, Marina E., 87-0626M (4/88)
Hamilton, Robert, 88-0194M (5/88)
Hamm, James E., 87-0277M (3/88)
Hammond, Robert, 87-0305M (1/88)
Hardy, Thomas C., 88-0180M (5/88)
Harlin, Betty, 87-0516M (6/88)
Harper, Betty L., 87-0763M (1/88)
Harris, Michael, 88-0135M (4/88)
Harris, Rex L., 88-0186M (5/88)
Harroun, Elden, 88-0215M (5/88)
Harvey, Herman C., Jr., 87-0521M (4,5/88)

Name, WCB Number (Month/Year)

Hayes, Larry L., 85-0393M (1/88)
Helvie, John S., 88-0018M (1/88)
Hendricks, James, 86-0640M (6/88)
Hendrickson, Shirley, 86-0169M (1/88)
Henshaw, Johnny L., 84-0588M (5/88)
Herron, James M., 86-0466M (2/88)
Hickman, Donald, 88-0072M (3/88)
Hicks, Kenneth B., 88-0238M (5,6/88)
Hoff, Harley, 84-0032M (4/88)
Hoke, Harold L., 84-0476M (2/88)
Hollingsworth, Nettie, 88-0199M (5/88)
Holst, Albert S., 87-0530M (1/88)
Holt, Danny, 88-0060M (5/88)
Hornberger, Julia M., 85-0137M (2/88)
Howard, David, 88-0300M (5/88)
Hunter, John H., 88-0139M (4/88)
Hylton, Bobby G., 87-703M (2/88)
Imbler, George L., 88-0127M (4/88)
Isaacs, Minnie, 88-0237M (5/88)
Jackson, Eugene, 83-0153M (1/88)
Jackson, Hilda, 88-0011M (1/88)
Jackson, Howard, 87-0656M (1/88)
Jacobs, Jim G., 88-0192M (5,5,6/88)
Janzen, Clarence, 87-0649M (2/88)
Jensen, Leonard J., 86-0694M (3,5/88)
Jesperson, Diane, 88-0204M (5/88)
Johnson, Daryl, 88-0267M (5/88)
Johnson, Robert H., 87-0758M (2/88)
Johnson, Susanne, 88-0112M (4/88)
Jones, Roy L., 88-0205M (5/88)
Jones, Steven R., 87-0726M (1/88)
Jones, Tim, 88-0179M (4/88)
Joseph, Elaine, 87-0740M (5/88)
Joy, Patricia, 88-0198M (5/88)
Kellison, Dolores, 88-0024M (2/88)
Kellogg, Lawrence L., 86-0607M (6/88)
Kelly, David D., 88-0143M (4/88)
Kelly, John R., 87-0679M (5/88)
Kendall, Ronald, 88-0347M (6/88)
Kennedy, Kenneth, 88-0240M (5/88)
Kent, Hazel, 87-0572M (3/88)
Ketchum, Myron H., 87-0757M (1/88)
Kibbey, Ralph, 88-0239M (5/88)
Kleger, John P., 88-0063M (3/88)
Knowland, Laurey J., 87-0761M (2/88)
Knowlson, James C., 88-0271M (5/88)
Korhonen, Robert, 87-0695M (2/88)
Kretschmer, Patrick L., 88-0210M (5/88)
Lacy, Lois A., 88-0049M (2/88)
Lane, Cameron, 87-0748M (6/88)
Lang, Terry, 88-0211M (5/88)
Langston, Bradley, 88-0201M (5/88)
Larose, Betty, 88-0315M (6/88)
Larsen, Frank E., 86-0686M (6/88)
Lathrop, Daniel, 88-0050M (2/88)
Lauritsen, Kerry L., 86-0570M etc. (3/88)

OWN MOTION JURISDICTION 1988

Name, WCB Number (Month/Year)

Ledoux, Martin, 87-0731M (1,4/88)
Lee, Patricia, 88-0075M (4/88)
Lehrmann, James, 88-0259M (5/88)
Lemar, Ruby, 88-0253M (5/88)
Lewis, Wilbur A., 87-0540M (1/88)
Linton, Gregg, 88-0196M (5/88)
Lockwood, Betty C., 88-0021M (2/88)
Logsdon, E.V., Jr., 88-0131M (4/88)
Lomas, Michael H., 87-0319M (3,4/88)
Louvring, Gordon E., 87-0343M (1/88)
Lovell, Robert P., 88-0124M (4/88)
Lutes, Stephen G., 87-0201M (1/88)
Luyet, Michael, 86-0086M (2/88)
Lynch, Raymond D., 88-0203M (5/88)
Mangun-Wolverton, Beverly, 88-0147M (5/88)
Mansker, Howard, 88-0266M (5/88)
Mansker, Melba S., 87-0612M (1/88)
Maplesden, Amos A., 88-0269M (5/88)
Marsh, Michael L., 88-0015M (2/88)
Marshall, Raymond, 88-0047M (2/88)
Marston, Ron, 88-0074M (3/88)
Martin, Jack W., 88-0148M (4/88)
May, George R., 87-0136M (5/88)
McAdams, Valdean, Jr., 88-0283M (5/88)
McAlister, J.D., 88-0218M (5/88)
McCann, Herbert I., 88-0010M (1/88)
McCord, Flint L., 88-0051M (2/88)
McDaniel, William J., 88-0299M (6/88)
McDarment, Dorotha L., 87-0741M (5/88)
McGuire, Marc W., 87-0759M (1/88)
McKenzie, George J., 88-0236M (5/88)
McKinstry, Karri, 88-0223M (5/88)
McMahan, Claude A., 88-0123M (4/88)
McMullen, John M., 88-0216M (6/88)
Miller, Bernard, 88-0032M (4/88)
Miller, David R., 87-0204M (3,6/88)
Miller, George Irving, 87-0217M (4/88)
Miller, Merle, 88-0022M (1/88)
Montes, Antonio, 88-0242M (5/88)
Montgomery, Robert L., 88-0172M (5/88)
Moon, Jerry D., 88-0102M (4/88)
Moore, Judith A., 86-0332M (6/88)
Morehead, James, 88-0073M (3/88)
Morgan, Linda, 88-0030M (2/88)
Mossman, Leslie W., 86-0326M (5/88)
Mullen, Gary L., 87-0481M (5/88)
Munson, Karen, 88-0284M (6/88)
Newingham, Donald, 88-0291M (5/88)
Newton, Jack A., 86-0061M (1/88)
Nichols, Steven, 87-0734M (1/88)
Niemann, David, 87-0095M (5/88)
Noggle, Richard, 87-0073M (2/88)
Northrup, Frank, 88-0079M (2/88)
Oakes, Reeford, 88-0069M (2/88)
Oland, Delmar G., 87-0037M (4/88)
Olson, Robert O., 85-0297M (1/88)

Name, WCB Number (Month/Year)

Parks, Robert, 88-0191M (5/88)
Parr, Chester, 88-0292M (6/88)
Pepper, Wanda, 88-0133M (6/88)
Pershall, James, 88-0013M (1,2/88)
Petrie, Terry A., 86-0096M (2,5/88)
Phibbs, Rena E., 88-0076M (4/88)
Philippi, Wesley I., 87-0410M (6/88)
Pieri, John, 88-0275M (6/88)
Potts, Clarence, 87-0469M (1/88)
Powell, Edgar, 85-0656M etc. (2,3/88)
Powell, James H., 87-0045M (1/88)
Prince, Ashley, 88-0341M (6/88)
Pruitt, Willie, 88-0025M (1/88)
Quinlan, Karen M., 87-0492M (6/88)
Rapoza, Robert K., 88-0084M (3/88)
Rauschert, John L., 87-0357M (1,2/88)
Ray, Robert A., 88-0184M (5/88)
Reason, Lynett, 87-0765M (4/88)
Reese, Georgia L., 87-0646M (1/88)
Reynolds, Becky J., 87-0427M (1/88)
Rice, Richard L., 88-0255M (5/88)
Richards, Stanley L., 87-0210M (5/88)
Rickard, Ruth A., 88-0126M (4/88)
Riggs, Wilbur, 88-0150M (4/88)
Riley, John B., Sr., 87-0751M (1,6/88)
Roberts, Donald L., 87-0621M (1/88)
Roberts, George E., 88-0006M (3/88)
Rogers, Brian, 87-0010M (3/88)
Rogers, Walter Earl, 88-0141M (5/88)
Ross, Charles A., 88-0066M (3/88)
Ross, Patricia, 88-0118M (4/88)
Rowan, John T., 86-0413M (2/88)
Samuelson, Glenda, 88-0092M (5/88)
Sanford, Dolly A., 88-0169M (4/88)
Schafer, Franklin M., 87-0523M (1/88)
Schiller, John, 87-0257M (1/88)
Schuster, Danny, 88-0350M (6/88)
Self, Ira D., 86-0242M (5/88)
Shine, Donn, 88-0012M (6/88)
Shine, Patrick J., 88-0289M (5/88)
Shingledecker, Irma L., 86-0359M (1/88)
Shipman, Orville D., 87-0680M (3/88)
Short, Kenneth, 86-0387M (1/88)
Shumaker, Glenn, 88-0128M (4/88)
Smith, Betty J., 88-0290M (6/88)
Smith, David A., 88-0160M (4/88)
Smith, David R., 88-0002M (1/88)
Snyder, James F., 88-0162M (4/88)
Souza, Joseph, 88-0029M (2/88)
Spencer, Mary I., 88-0042M (4/88)
Steen, Donald R., 86-0537M (4/88)
Stephens, John R., 86-0019M (3/88)
Stewart, Albert F., 88-0213M (5/88)
Stoltenburg, Roy R., 88-0154M (5/88)
Stone, Jim L., 88-0008M (2/88)
Strauss, Steven J., 88-0219M (5/88)

Name, WCB Number (Month/Year)

Swartout, Sara I., 87-0652M (5/88)
Sweet, Gary, 88-0202M (5/88)
Swindler, James, 88-0156M (4,5/88)
Tamerius, Gordon, 87-0650M (1/88)
Taskinen, Richard J., 88-0086M (3/88)
Thayer, Alvin, 88-0009M (2/88)
Thissell, John O., 88-0035M (2/88)
Thomas, Candy V., 87-0203M (3/88)
Thompson, Sam, Jr., 85-0516M (4/88)
Tichenor, Dale L., 88-0183M (6/88)
Tindall, James, 88-0095M (4,6/88)
Toman, Stella, 88-0068M (2/88)
Tompkins, Theodore, 87-0602M (1/88)
Towns, Jerry, 88-0157M (4/88)
Townsend, Randy L., 88-0217M (5/88)
Tribur, Harold, 85-0493M (5/88)
Tunnell, Marsha, 88-0305M (5/88)
Underhill, Thelma L., 88-0087M (6/88)
Valle, Isaias, 87-0477M (5/88)
Vandehey, Kim M., 88-0256M (5/88)
Vargas, Ricardo, 88-0268M (5/88)
Wade-Wilson, Teresa, 88-0254M (6/88)
Wagenius, Ann, 88-0244M (6/88)
Walker, Edward, 85-0397M (1/88)
Warner, Jim N., 87-0002M (2/88)
Webb, Andy, 88-0144M (4,5/88)
Wells, Earl, 88-0107M (3/88)
Werner, Diane, 88-0164M (4/88)
Wheatley, Roy T., 86-0349M (4,5/88)
Wheeler, Harriette, 88-0046M (2/88)
White, Frank R., 87-0698M (1/88)
Whitethorn, Rick, 88-0142M (4/88)
Wilburn, James, 88-0153M (4/88)
Wild, Karl, 87-0411M (1,2,2/88)
Williams, Gary E., 87-0749M (1/88)
Williams, Glenn M., 88-0090M (3/88)
Williams, Robert H., 87-0730M (3/88)
Williamson, Walter, 88-0226M (5/88)
Wilson, Suzanne, 87-0393M (1/88)
Winter, Michael, 88-0040M (2/88)
Wolf, Paul, 88-0111M (4/88)
Woodman, Donald E., 88-0110M (4/88)
Woodruff, Ellanora, 87-0307M (5/88)
Wooldridge, Michael, 87-0577M (4/88)
Wright, Bill M., 88-0280M (6/88)
Wright, Susan K., 87-0415M (5/88)

CLAIMANT INDEX 1988

Claimant (WCB Number and/or Court Number)------page(s)

Adair, Royce D. (86-09629)------479
Adams, James W. (WCB 84-10811; CA A41735)------624
Aguiar, Marco (84-05596)------3,85
Akerson, Robert L. (85-14555 & 86-11545)------12,129
Alcala, Pedro G. (86-05800)------26
Aleshire, Jeanette M. (86-11759)------73,98,326
Allen-Adams, Arlene B. (86-00799)------115
Apodaca, Ricardo (88-0297M)------532
Arciga, Jose L. (86-13690)------73
Argonaut Insurance (WCD 86-03387; CA A43764)------268
Armstrong, Robert D. (WCB 86-02776; CA A45124)------616
Arnold (CA A39775)-------244
Avalos, Antonio S. (WCB 84-04390; CA A40155)------264
Babbitt, Danny L. (88-0187M)------455
Bagwell, Susan A. (87-0424M)------99
Bannester, Jessica G. (CV-88003)------400
Barnett, Charles V. (87-14849)------401
Barresse, Andrew W. (86-02826)------93
Bass, George F. (87-0632M)------437
Beaman, Linda S. (86-06892)------8
Beasley, Esther C. (85-06921)-------70
Beaty, Robert J. (84-0198M)------35
Beavers, Clyde (87-0012M, 87-0013M & 87-0014M)------64
Beebe, Roy D. (86-11931)------539
Bell, Forrest (88-0320M)-------509
Bement, John H. (87-145570)------437
Benson, Toria S. (855-14056 & 84-01712)------580
Bergmann, Daniel J. (87-0737M)-------325
Berliner, Dennis (WCB 85-12191; CA A43382)------629
Billups, Terry L. (86-13726)------403
Bishop, Thomas E. (85-05791)------11
Blacknall (CA A43239)----------234
Blakeley, Margaret F. (WCB 84-02190; CA A40273)------271
Bochart, Lester W. (85-04847)------470
Boehland, Gregory D. (87-08237 & 87-07488)------555
Bond, Donald P. (TP-88001)------361,480
Borgelt, Elaine M. (TP-88002)-------108
Bowman, Denise M. (87-18040)------363
Bradley, Carl R. (86-17149 & 86-14461)------406
Breeden, Luann M. (87-09362)------407,510
Bristow, Deane G. (86-12484)------26
Britt, Shirley A. (86-05940)--------44
Brogan, Virgil (86-12575)------67
Brotherson, Royd C. (87-16806)------594
Brown, Barbara J. (85-15686)------25
Brown, Curtis (86-04530)------389
Brown, Earl M. (86-00251)------15,129
Brown, Franklin (86-08044)------87
Brown, James M. (88-0173M)------458
Brummett, Bryce D. (86-06567)------99
Bruner, Michael D. (88-0065M)------74
Buckle, Jerry V. (86-00040)------74
Burns, Robert D. (86-12488)------397,610
Burruss, Margrette M. (88-0098M)------365
Burton, Jack (87-0674M)------64
Buzard, Leon C. (84-09887 & 85-05168)------595
Campos, Maria (87-08331)------408
Carpenter, Greg (87-12941)------100,349

CLAIMANT INDEX 1988

Claimant (WCB Number and/or Court Number)------page(s)

Carroll, Linda L. (87-17793)------471
Cave (Jackson), Sharon L. (86-08980)------39
Chambers, Leonard A. (87-03511)------117,610
Chambers, Steve (88-0222M)------467
Chemnitzer, Dennis L. (86-13136)------409
Childers, Earl F. (85-14969)------481
Coen, Gale E. (87-06839)------556
Collins, Sanford E. (87-06676)-------128
Connell, Jan (88-0078M)------325
Cooper, Robert W. (87-12403 & 87-07354)------486
Corbin, Dave Wendell (88-0052M)------510
Cowart, Leon E. (84-02070)------22
Cruchelow, Timothy H. (86-06981 & 86-06982)------411,511
Cruickshank, James G. (87-07939)------539
Damis, Vlassios (WCB 85-06061; CA A42156)------241
Daniels, Janet R. (TP-88003)------488
David (86-09206)------72
Davidson, Cathey M. (86-17404 & 86-08865)------596
Davis, Carol (85-00169 & 86-10997)------35,129,130
Davis, Delbert G. (86-09371)------390
Davis, Desi R. (87-08233)------540
Davis, Dewey (88-0058M)------349
Davis, Wallace J. (87-0744M)------588
Davis, William D. (WCB 86-06476; CA A44676)------649
Daza, Charlotte J. (86-10179)------4
Dean, Daren H. (86-08300)------95
Delanoy, Conrad, Jr. (88-0106M)------348
DeMarco, Steven M. (85-01456)------100
Denny, Carol (85-15708)------101
Desmarais, Cecile R. (87-18580)------365
DeSylvia, Thomas E. (WCB 84-13344 etc.; CA A41813)------660
Dietz, Dewey L. (88-0101M)------348
Dillman, Paul E. (87-08543, 86-14301 & 87-08542)------489
Doak, Wade A., 86-09423)------95
Doggett, Kenneth M. (88-0038M)------354
Donaldson, Robin O. (87-07005)------429
Doringer, Lorraine (88-0121M)------351
Dragt, Toni A. (86-06588 & 86-05442)-------29
Duffy, Patrick (86-08009)------118
Dumas, Marian S. (86-08169)------109
Dunbar, Arlo W. (TP-87017)-------366,491
Dunn, Sharon M. (WCB 84-13386; CA A39337; SC S34836)------700
Duran, Francisca A. (85-03909 & 85-06267)------38
Ebbert, Robert G. (87-04189)------67
Eckstein, Virgil M. (86-10546)------12
Eddy, Donn (86-11859)------524
Edens, Glen L. (84-07667, 82-09893 etc.)------326
Eder, Jane (WCB 85-09171; CA A42239)------259
Elicker, John T. (TP-87031)------68,413
Ellena, Anthony D. (85-00709)------72,101
Ellis, Joyce A. (86-07849)------119
Erck, Ernest F. (86-05134)------49
Erickson, Deborah S. (86-15003)------599
Erickson, Jessie (87-00435)------438
Erickson, Terry J. (86-13441)------75
Evans, Hubert E. (87-00647)------121
Farley, Douglas L. (86-09282)-------30
Fenton, Emma J. (84-02176)------45
Fischer, Richard (86-04217)------75

Claimant (WCB Number and/or Court Number)------page(s)

Fisher, Carol A. (87-15218 & 87-12543)------458,610
Fisher, Deryl E. (83-01466)------101
Fitzgerald, Gayle L. (87-0471M)-------127
Flickinger, Buddy A. (86-18024)------543
Flint, David C. (86-08398)------558
Foster, Jerry F. (WCB 84-11283 etc.; CA A43398)------622
Francis, Jeffrey L. (86-12078)------561
Frank, Leroy (88-0059M)-------70
Fromme, Cherryl Ann (WCB 85-10042; CA A42360)-------255
Gabbard, Larry R. (87-07454 & 86-13512)------414,491
Gaines, Rodger L. (86-08172 & 86-08173)------94
Garoutte, Howard (86-0563M)------76
Garrelts, Ralph H. (87-17585)------511
Geddes, Donald E. (WCB 83-11452 etc.; CA A42025)------276
Gentry, Alice M. (88-0195M)------447
George, Dorla R. (WCB 86-00300; CA A45380)------635
Gibson, Douglas (87-0550M)------128
Gilbert, Gary L. (86-14534)------562
Godaire, Raymond P. (86-16907)------564
Goodenough, Elbertia (88-0193M)------359
Gordon, William C. (87-01952)-------577
Greenslitt, Martin (WCB 82-00591; CA A41824; SC S34680)------683
Gregory, Timothy W. (TP-87023)-------45
Griffith, Sherman V. (85-11244, 85-05496 & 85-08267)------121,610
Grover, Barton M. (WCB 85-14800 etc.; CA A43932)------631
Guill, Margie M. (85-09065; CA A42368; SC S34681)------688
Gwynn, William R. (WCB 84-11354; CA A38534)------638
Haines, Evelyn G. (87-16280)------333
Hale, Gilbert T. (85-12110 & 86-15750)------513
Halfmoon, Ramona K. (87-12383)------447
Hamar, Sidney C. (86-17566)------334
Hamel, Frank A. (86-14217)------418
Hammons, Olen B. (88-0105M)------355
Hansen, Ronald G. (WCB 83-03734 etc.; CA A41772)-------250,472
Harris, Claude E. (87-16670)------335,611
Harris, Franklin A. (86-17125)------77
Hartley, John D. (86-17365)------327
Hatleli, Bruce A. (85-02089, 85-04106 etc.)------38
Heffley, Marvin R. (87-04796)------391
Henderson, Leonard (TP-87007)------31
Henneberg, Walter D. (87-13896)-------109,357
Henshaw, Johnny L. (84-11637 & 84-11638)------468
Herrod, Jeanette L. (87-08338)------368,491
Hess, Theresa L. (86-13594)-----25
Hilliker, Irene (88-0097M)------464
Hinton, Gil T. (87-00414 & 86-08265)------465
Hobkirk, Elsie L. (87-04327)-------4
Hogan, Alva P. (86-09174)------565
Howard, Rick W. (86-13575)------77
Hughes, Howard E. (WCB 84-12107; CA A39769; SC S34107)------291
Hunsley, Harry N. (85-02203)-------40
Hunter, Gary (87-0735M)------58
Hunter, Terry L. (84-13275; CA A39205)------659
Hutton, Deborah A. (TP-87019)------34
Ingalls, Richard R. (86-03202)------122,611
Jackson, Robert D. (85-08850)------51,95
Janzen (CA A38634)-------614
Jebens, Peter G. (86-09843)------370
Jenkins, Leonard V. (85-07550)------39

Claimant (WCB Number and/or Court Number)------page(s)

Jewell, Mark W. (87-02616)------492
Joers, Harry A. (86-16915 & 86-14634)------110,612
Johnsen, Merlyn G. (WCB 83-06970; CA A42318)------227,281
Johnson, Chester (87-02828)------336
Johnson, Diane L. (86-0320M)------80
Johnson, Julie E. (87-13332)-----419,515
Johnson, Matthew W. (87-14136)------393
Johnson, Paul M. (87-09212)------532
Johnson, Ramey S. (87-06194)------370
Johnston, Bryan W. (86-01069)------58
Keller, Edwin L. (87-09000)-----351
Kelley, Edward J. (86-03841)------114
Kelly, Charla J. (87-15241)------337
Kentner, Yvonnda M. (86-09790)-------43
Kephart, Archie F. (WCB 81-0173M; CA A43061)------633
Keuscher, Anita L. (86-06175)------398
Kleger, John P. (87-04131)------96,345
Klein, Tracy (87-0704M)------352
Knapp, Edgar Jason (CV-87009)------433
Krajacic, Steve (WCB 84-02476; CA A37693)------632
Krause, Joanne C. (WCB 86-05815; CA A42526)------239
Kunkler, Donald J. (87-01470 & 86-16858)------421
Lane, Beverly (88-0221M)------466
Lane, Forest M. (84-00603, 85-05722 & 86-03548)------338
Leavitt, Lance E. (87-18345)------393
Legarde, Alfred (87-16857)-------371
Lejeune, Theodule, Jr. (86-12737)-------102,493
Lenocker, Paul (87-0624M)------352
Liacos, Leon V. (TP-87030)------102,339
Link, Terry L. (86-01751)------17,130
Lloyd, Harlene A. (86-05744)------92
Lopes, Tomas M. (86-15237)------106
Lowery, Ronald E. (88-0070M)------94
Lubitz, Steven B. (TP-88005)------450
Luckman, Rockne (85-12369 & 86-04809)------80,130,328
Luna, Richard A. (87-03680)------430,516
Lund, Kathryn E. (84-13179 & 85-13116)------342
Lyday, Ronald M. (86-06814)-------114
Macaitis, Wilma F. (87-06841)------373
Manning, Martin (87-14815 & 87-13538)------374
Martin, Angeline C. (87-00076)------432
Martin, Elson (88-0152M)------439
Martinez, Maria (85-04637, 86-04133 & 86-05155)------59
Martinez, Maria (87-02506, 87-01443 & 87-17747)-------57
Mathis, Jimmy (WCB 83-10182; CA A40761)------636
Mayfield, John E. (88-0096M)-------328
McBroom, Thomas (TP-87029)------495,593
McCoy, Steve D. (88-0125M)------329
McDonald, Frankie L. (87-10673)------440,612
McFarland, Mary (WCB83-06254 etc.; CA A40544)------236
McGhee, William W. (87-0079M)------457
McGill, Clinton S. (CA A44217)------647
McKellips, Marcia M. (86-11056)------608
McLain, Luther R. (88-0088M)-------122
McMillan, Ruth B. (88-0233M)------508
McNaught, Carol A. (88-0134M)------353
McRorie, Michael K. (86-09646)------516
Mendoza, Maria C. (88-01994)------499

Claimant (WCB Number and/or Court Number)------page(s)

Miller, Jerry R. (87-06381 & 87-10549)------376
Miller, Russell (WCB 84-13597; CA A39349; SC S34840)------696
Mills, Paula M. (87-06034)------500
Mindt, Herbert D. (87-13295)------602
Miner, Bertha J. (84-10842)------518
Minsker, Michael (88-0132M)------358
Mischel, Henry L. (WCB 82-10262 etc.; CA A41734 etc.)------231
Misenhimer, Clarence W. (87-03439 & 86-09600)------343,395
Moore (CA A41885)------653
Moore, Richard A. (WCB 86-00561; CA A44104)------278
Moore, Samie J. (85-02704)------545
Morgan, Michael (87-07167, 87-13050 & 87-15253)------378
Morris, George F. (87-03440 & 87-11137)------545
Morss, Agatha (88-0189M)------452
Moustachetti, Marvin L. (87-04966)------106,344
Murk, Quinn J. (88-0272M)------520
Murphy, Robert L. (86-06489)------423,442
Neal, Janelle I. (87-09194)------359
Neeland, Robert S. (86-0154M, 86-0155M & 86-0156M)------52
Neihart, Ward (WCB 85-13216; CA A42468)------628
Neill, Merrick L. (87-12535)------425
Nelson, Allen W. (86-15611 & 87-04121)------53
Nelson, Allen W. (87-0515M)------56
Newkirk, Beverly (WCB 85-11733; CA A42695)------620
Newman, Wayne L. (85-06437)------355
Nicholson (CA A40516; SC S34421)------693
Nickle, Penny L. (87-09156)------378,501
Nolan, William S. (WCB 85-12463; CA A41393)------228
O'Neil, Dan V. (87-11948)------531
O'Riley, John B. (86-01486)------443
Odam, Clarence W. (87-08441)------453
Oleachea, George R. (85-05633)------5
Olinghouse, Barbara D. (86-01750)------20,130
Oliver, Cynthia K. (87-19385)------466
Ommert, Philip M. (87-08220)------528
Orwick, Dale L. (86-16031)------353
Oseguera, Alicia (86-17204)------98
Palmer (CA A40845)------644
Payne, James L. (86-11360)------329
Perini, Robert A. (86-05896 & 86-16035)------395
Peterson, Rose J. (86-12839 & 86-12003)------105
Phibbs, Rena E. (88-0076M)------94
Picthall, Lillie A. (86-07342)------12
Piwowar, Leokadia W. (WCB 82-09391 etc.; CA A38112; SC S34285)-----674
Poole, Charles M. (86-08304)-------41,85
Powers, Vone M. (87-06413)------396
Preston, Annette (87-13133)------589
Priddy, Vernon (88-0258M)------508
Queener, Mark L. (WCB 85-08542 etc.; CA A41210)-------226
Randall, Grace (87-0762M)------62
Raymond, David H. (87-01143 & 87-01144)------536
Rendon, Simon Z. (87-03782)------425
Reyes, Robert L. (86-08493 & 86-09981)------608
Ridings, Ronald W. (87-12190)------502
Ring, Abraham W. (WCB 85-03639; CA A41872)------280,547
Rogers, Brian (87-0010M)------457
Rosenberger, John S. (CV-88002)------575
Rousseau, John L., Sr. (86-15587 & 86-15588)------115
Rumpel, Billie I. (85-01331)------123,612

Claimant (WCB Number and/or Court Number)------page(s)

Russell, Donna J. (87-05486)------568
Salzer, Sharon K. (85-12483)------345,445
Salzer, Sharon K. (87-06505)------347,446
Sampson, Fred T. (87-0528M)------360
Sather, Einar (88-0303M)------537
Sayre, Georgeanne M. (86-12720 & 86-13024)------82
Scarino, Mario (TP-87002; CA A45358)------655
Scrivner, John (87-12102)------472
Seibel, Buernell L. (CA A38803; SC S34101, S34152)------662
Sexton, Joseph (87-0560M)------331
Shea, Daniel A. (88-0036M)------82
Shipman, Orville D. (87-0680M)--------537
Short, Lee E. (CA A41221; SC S34725)------689
Smartt, Thelma T. (86-11704)------602
Smith, Leland (88-0308M)------473
Smith, Leland, Jr. (87-0418M)------356
Socia, Michael (88-0145M)------380
Spangler, Warren L. (87-0535M)------62
Sprague, Elnora (88-0100M)------354
Spurlock, Clara J. (WCB 85-03381; CA A43109)------261
Staack, Doris R. (85-03614, 85-01512 & 85-01511)------65
Stacy, Donald R. (87-10911)-------43,98
Steckmann, Ramona (86-08870)-----90
Steele, Thomas E. (86-09755)------383
Steiner, Raymond (TP-87024)------381
Stephens, Melinda J. (87-12650)------520
Stephens, Sharon D. (86-13748)------105
Stokes, Thomas J. (87-0754M)------83
Stokley, Edwin R. (87-08421)------397
Story, William G. (87-18257)-------129
Stovall, Pamela R. (WCB 84-13447 etc.; CA A38730; SC S33962)------701
Sullivan, Lawrence M. (82-10103)--------42
Surprise, Richard G. (WCB 85-03495; CA A42210)------246
Swoyer, John G. (87-03647)------606
Sykes, Robert F. (WCB 85-04503; CA A42587)------274
Tallard, Charles (88-0249M)------509
Tallent, Harold D. (85-09741)------91
Taylor, Richard F. (87-11524 & 87-14282)------384
Thissell, John (88-0171M)------356
Thomas, William D. (86-12643)------547
Thomison, Patrick (88-0166M)------332
Thompson, Ralph L. (88-0099M)------344
Thon, Janice G. (85-00402)------606
Thurston, Lewis (87-0686M)------456
Tripp, Martin E. (84-11895 etc.; CA A40342)------253
Tronson, Tommy L. (87-11240)------48,83
Turner, Harold (WCB 83-09731 etc.; CA A39913)------642
Utrera, Leonila C. (WCB 85-14220; CA A42877)------230,345
VanBlokland, Patricia M. (83-06632)------65
VanSanten, Karen K. (87-08817)------63
Varner, Dwayne L. (WCB 85-12134; CA A42724)------257
Vilanj, Frank A. (87-12285)------427,521
Vinyard, Berrell D. (86-12091)------474
Waggoner, Natalie (88-0188M)------358
Walker, Connie R. (87-06330)------84
Walker, Randy B. (86-02306)------124

Claimant (WCB Number and/or Court Number)------page(s)

Warrilow, Bryan D. (86-09029)------521,609
Warrington, Andrea L. (CV-87008)------1
Watts, Dwane (85-14239)------505
Webb, Andy (88-0144M)------586
Weise, Arlo A. (86-00105)------551
Whipple, Mike (86-06166)------572
White, Dawn (WCB 83-09151; CA A36411; SC S34192)------284,672
Whitney, Michael J. (86-08779)------332
Whittaker, Michael (88-0163M)------385
Whittlinger, Thomas H. (86-09059)------399
Wilken, Keith (87-0417M)------456
Wilkerson, Catherine (85-01964)------385
Williams, Arbra (86-05202)------506
Williams, Gregory K. (86-17641)------554
Wilson, Joseph (87-08970)------66
Wilson, Stanley (87-10010)------387
Wilson, Tana L. (87-16385)------476
Wilson, William H. (87-0068M)------444
Windom, Grant T. (88-0089M)------333
Wojick, Jerry E. (WCB 84-02193; CA A41590)------267
Ybarra, Jose (86-08841)------5,42