VAN NATTA'S WORKERS' COMPENSATION REPORTER

VOLUME 39

(Pages 631-1012)

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

JULY-SEPTEMBER 1987

Edited & published by:

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

CONTENTS

CITE AS

39 Van Natta ____ (1987)

MINA L. BROOKS, Claimant
Charles Maier, Claimant's Attorney
Roberts, et al., Defense Attorneys

WCB 85-14818
July 6, 1987
Order on Reconsideration

Claimant requests reconsideration of our Order on Review dated June 12, 1987. In that order we affirmed the Referee's order, which assessed a penalty and attorney fee for the self-insured employer's failure to pay temporary total disability compensation, travel expenses and medical billings in a timely fashion. The employer requested review of the Referee's order, and the sole issue on review was penalties and attorney fees. Although we affirmed the Referee's order, we did not award claimant attorney fees for services on Board review. Claimant asks that we reconsider our failure to award fees.

Claimant's request for reconsideration is granted. We withdraw our prior order for reconsideration. On reconsideration, we find that our prior order should stand. See Saxton v. SAIF, 80 Or App 631 (1986); Dotson v. Bohemia, Inc., 80 Or App 233 (1986). Therefore, having granted claimant's request for reconsideration, we adhere to and republish our prior order effective this date.

IT IS SO ORDERED.

DAVID E. CUMMINGS, Claimant
SAIF Corp Legal, Defense Attorney

WCB 86-00389
July 6, 1987
Order of Dismissal

The SAIF Corporation has moved the Board for an order dismissing claimant's request for Board review on the ground that the request was untimely filed. Although we conclude that the request was timely filed, we find that a copy of the request was not timely mailed to the parties. Consequently, the motion to dismiss is granted.

The Referee's order of dismissal issued November 3, 1986. On November 24, 1986, claimant mailed to the Board an envelope containing a letter and several documents. The Board received the envelope on November 26, 1986. Neither an acknowledgement of service nor a certificate of personal service by mail accompanied the envelope.

The submitted documents neither requested Board review nor specifically referred to the Referee's order. However, the materials were eventually interpreted to be a request for Board review of the Referee's order of dismissal and were processed as such. A computer generated letter acknowledging the request was mailed to the parties on January 12, 1987. This was apparently the employer's and SAIF's first notice of the request for review.

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).

In Argonaut Insurance Co. v. King, 63 Or App 847, 852 (1983), the court held that "compliance with ORS 656.295 requires that statutory notice of the request for review be mailed or actual notice be received within the statutory period." In King,

the request for review was timely, but copies of the request were never sent to the other parties. The "actual notice" referred to by the court was the Board's computer generated acknowledgement letter, which the evidence established was received by the insurer more than 30 days after the Referee's order was mailed. Inasmuch as the insurer's notice of the request for review was untimely, the court found that the Board lacked jurisdiction to consider the appeal.

Here, the request was timely filed. However, the record fails to establish that either the employer or SAIF received a copy of the request for Board review. Moreover, neither party received actual knowledge of the request within the statutorily required 30-day period. Consequently, we lack jurisdiction to review the Referee's order of dismissal, which has become final by operation of law. See ORS 656.289(3), Argonaut Insurance Co. v. King, supra.

We are mindful that claimant was unrepresented by counsel when he submitted his request for Board review. 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. 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 J. DALE, Claimant
Roger D. Wallingford, Claimant's Attorney
SAIF Corp Legal, Defense Attorney

Own Motion 87-0029M
July 6, 1987
Own Motion Order and Determination on Reconsideration

The SAIF Corporation has requested reconsideration of the Board's February 26, 1987 Own Motion Order and Determination. Pursuant to our prior order, claimant's November 29, 1978 injury claim was reopened for the payment of temporary total disability compensation between September 4, 1986 and October 12, 1986, less time worked. In addition, claimant's attorney was awarded 25 percent of the increased compensation granted by our order, not to exceed $250. Finally, the claim was also closed, without further disability compensation.

SAIF has asked that our prior order be amended to allow it to offset the temporary disability award against a previous overpayment of temporary disability benefits. In support of its request, SAIF has enclosed a January 29, 1985 stipulation in which the parties agreed that a $1,391.41 overpayment "shall stand as an offset against any future compensation to be paid in this claim." Claimant objects, asserting that the offset was intended to be applied only against future awards of permanent disability.

We addressed a similar issue in Harold D. Bates, 38 Van Natta 992 (1986). In Bates, with one member dissenting, we affirmed a Referee's order that had approved an offset of overpaid temporary disability compensation against any future permanent disability awards. In so doing, we implicitly rejected SAIF's

contention that it should also be authorized to offset the overpayment against currently due temporary disability compensation.

Here, as in Bates, SAIF is attempting to recover an overpayment from currently due temporary disability benefits. The only distinction from Bates appears to be the January 1985 stipulation. Yet, the stipulation does not specifically authorize the recovery of the overpayment from temporary disability benefits. Rather, the stipulation provides for recovery from "any future compensation." Moreover, since offsetting the overpayment against currently due temporary disability benefits would be invalid, we interpret the phrase "future compensation" as a reference to benefits against which an overpayment may be lawfully offset. Such compensation could only refer to future permanent disability awards. See ORS 656.268(4); OAR 436-60-170; Bates, supra.

Accordingly, our prior order is withdrawn. On reconsideration, based on the aforementioned reasoning, SAIF's request for permission to recover an overpayment against temporary disability compensation is denied. Consequently, as supplemented herein, we adhere to and republish our February 26, 1987 Own Motion Order and Determination in its entirety, effective this date.

IT IS SO ORDERED.

MARC D. MARDIS, Applicant
Ann Kelley, Ass't. Attorney General

WCB CV-87004
July 6, 1987
Crime Victim Order

Applicant has requested review by the Workers' Compensation Board of the Department's Findings of Fact, Conclusions and Order on Reconsideration dated January 7, 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: (1) applicant's failure to cooperate fully with law enforcement officials to prosecute his alleged assailant; and (2) evidence that applicant may have substantially contributed to his injuries by provoking the alleged assailant or voluntarily entering into the altercation.

Following our receipt of the request for Board review, applicant was advised that he was entitled to present his case to a Hearing Officer. In response to our notification, applicant stated that he desired a hearing, but lacked transportation. Consequently, he requested that his case be considered based on the record furnished by the Department. On April 1, 1987, we notified applicant that an alternate hearing site could be arranged. Accordingly, applicant was asked to notify us if he desired a hearing. If no response was forthcoming within 20 days, applicant was advised that we would assume that he wished the review to proceed based on the written record.

Inasmuch as no further response from applicant has been received, we have reviewed this case based on the written record. The standard of review for cases appealed to the Board under the Compensation of Crime Victims Act (Act) is de novo 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 documentary evidence, we make the following findings.

Applicant contends that he was the innocent victim of an unprovoked assault. According to his claim for benefits, he was attacked at approximately 4:00 a.m. on May 30, 1986, while sleeping on a beach. He identified his assailant as Mark Abbott, but also stated that others had assisted in the attack. Once he extricated himself from the situation, applicant promptly reported the attack to Port of Portland police officials.

Officer Gomez conducted the investigation. According to the investigation report, applicant stated that he had been attacked with "fists, sticks, or feet" by several individuals while at a keg party. Applicant was bleeding from the mouth and nose. In addition, his throat was scratched and his left knuckles were lacerated.

Shortly thereafter, Abbott was contacted at the beach. Abbott admitted that an altercation had occurred. However, Abbott insisted that the fight had started when applicant grabbed him around the neck and threw him to the ground. Abbott stated that the fight concerned applicant's insistence that he be repaid for the costs of the keg. Abbott further claimed that only he and applicant were involved in the fight. Rachelle Day, Abbott's girl friend, confirmed this latter point. In addition, she noted that applicant had been harassing people the entire night.

After applicant performed a "private citizen" arrest, Abbott was issued a misdemeanor citation for the offense of Assault IV. After setting a June 12, 1987 hearing date for the citation, Officer Gomez referred the case to the District Attorney's office for prosecution. When neither applicant nor any witness appeared at the hearing, the case was rejected.

Applicant was hospitalized from May 30, 1986 through June 3, 1986. In addition to the aforementioned cuts and abrasions, he sustained a broken jaw and chest contusions. Closed reduction surgery was necessary to repair the fractured jaw.

It is applicant's contention that his hospitalization and surgery prevented him from attending the June 12, 1986 hearing. Furthermore, he asserts that his injured jaw and the residual effects from anesthesia rendered him unable to testify or otherwise participate at the hearing.

CONCLUSIONS

Pursuant to ORS 147.015, applicant is entitled to an award under the Act, if, among other requirements:

> "(3) [He] has cooperated fully with law enforcement officials in the apprehension and prosecution of the assailant or the department has found that [his] failure to cooperate was for good cause."
>
> "(5) The death or injury to the victim was not substantially attributable to the wrongful act of the victim or substantial provocation of the assailant of the victim."

Following our de novo review of this record, the preponderance of the evidence fails to establish that applicant is

entitled to an award of compensation under the Act. See ORS 147.015(3) and (5). Accordingly, we conclude that the Department's Order on Reconsideration should be affirmed.

Applicant promptly notified police officials of the altercation and assisted in the issuance of a citation. Yet, he did not appear at the scheduled hearing. Inasmuch as his absence substantially contributed to the rejection of the case for prosecution, we find that applicant failed to fully cooperate with law enforcement officials. Thus, he is not entitled to receive benefits as the victim of a crime. See ORS 147.015(3).

Applicant contends that his hospitalization, surgery, and subsequent convalescence prevented him from appearing at the hearing or participating in the proceedings. Other than this conclusory contention, there is no opinion, medical or otherwise, regarding applicant's physical capacity on or about June 12, 1986. Without further support, we find this contention insufficient to establish "good cause" for applicant's failure to cooperate with law enforcement officials in the prosecution of the case.

Furthermore, even if applicant was incapable of appearing at a hearing, which parenthetically was held approximately nine days after his release from the hospital, we are not persuaded that this disability prevented him from notifying the appropriate officials of his predicament. Had he, or his representative, provided timely notification, we are confident that the proceedings could have been rescheduled. However, whether intentional or not, applicant's failure to contact law enforcement officials resulted in the case's termination. Accordingly, we find his explanation unpersuasive and conclude that he failed to fully cooperate in the prosecution of his alleged assailant.

Assuming that we had found applicant's cooperation satisfactory, we would still find that he was not entitled to an award of compensation. The record has failed to establish that applicant's injury was not substantially attributable to either his wrongful act or his provocation of the alleged assailant. See ORS 147.015(5).

Applicant's contention that he was the innocent victim of an unprovoked attack is rebutted by Abbott's description of the altercation. Moreover, the only other statement in the record, albeit from the alleged assailant's girl friend, supports Abbott's version of the fight. Considering the circumstances surrounding this event, we do not find one version of the altercation any more persuasive than another. Consequently, the evidence is insufficient to satisfy the eligibility requirements of ORS 147.015(5).

ORDER

The Findings of Fact, Conclusions and Order on Reconsideration of the Department of Justice Crime Victim Compensation Fund dated January 7, 1987 is affirmed.

CONNIE W. PALM, Claimant
Roll & Westmoreland, Claimant's Attorneys
Norman Cole (SAIF), Defense Attorney

WCB 85-10022 & 85-10021
July 6, 1987
Order on Review

Reviewed by Board Members Lewis and McMurdo.

The SAIF Corporation requests review of those portions of Referee Mulder's amended order that: (1) set aside its denial of claimant's newly discovered cervical condition; and (2) set aside its denial of claimant's aggravation claim. The issues are compensability of the cervical condition and aggravation.

We affirm that portion of the order that found claimant's newly discovered cervical condition compensable. We reverse that portion of the order that concluded claimant had suffered an aggravation.

Claimant suffered a compensable upper dorsal back injury in 1983. In October 1983 she received a Determination Order awarding no permanent disability. Subsequently, the claim was reopened and in October 1984 a second Determination Order issued awarding no permanent disability.

In May 1985 a hearing was held to determine the extent of claimant's permanent disability. Medical reports of Drs. Button and Long noted that claimant was suffering from a chronic myofascial pain syndrome with a suggestion of radiculopathy. At hearing, claimant complained of severe pain in her neck, between her shoulders and radiating into the arms. She stated that the pain had prevented her from keeping several jobs. The Referee awarded 15 percent unscheduled permanent disability.

In June 1985 Dr. Nash reported that a CT scan had demonstrated a large central disc with right sided lateralization at C6-7. The scan also revealed a minimal bulge at C5-6. Based on these findings, claimant was referred to Dr. Berkeley, neurosurgeon. A myelogram confirmed the defect at C6-7 and Dr. Berkeley recommended a discectomy and fusion. Subsequently, the insurer denied both the newly discovered cervical condition and an aggravation claim.

In finding that claimant had established an aggravation, the Referee relied on Dr. Nash's report and the medical reports as a whole to conclude that her condition had worsened. We disagree.

In order to establish an aggravation claim, claimant must show "worsened conditions resulting from the original injury." ORS 656.273. To prove a worsening of her condition, claimant must establish that she is more disabled, meaning less able to work, than she was at the time of the last award or arrangement of compensation. Smith v. SAIF, 302 Or 396, 399 (1986).

The reports of Drs. Long, Nash and Berkeley all note the discovery of the cervical disc defects. Further, Drs. Nash and Berkeley agree that the cervical disc defect has caused claimant's symptoms of pain. Yet, despite the change in the diagnosis, none of the subsequent medical reports indicate that claimant's condition has worsened. The discovery of the cervical defects may account for the symptoms of pain that claimant has in her neck, upper back and radiating into her arms, but it does not indicate that she is more disabled than at the time of the May 1985 hearing.

Further, claimant's testimony does not support a worsening

of her condition. Claimant testified that her symptoms of pain at the June 5, 1985 examination by Dr. Nash were the same as when she appeared at the May 1985 hearing. She described the pain as "constant" and as having been with her so long "that it's a part of me now." Claimant's testimony does not indicate that she is more disabled than at the time of the last arrangement of compensation.

Consequently, we conclude that claimant has failed to establish a worsening of her condition.

We find the compensability issue to have been of average difficulty with an ordinary likelihood of success on Board review. A reasonable attorney fee is therefore awarded.

ORDER

The Referee's amended order dated October 22, 1986 is reversed in part and affirmed in part. That portion of the order that set aside the denial of claimant's aggravation claim is reversed. The remainder of the order is affirmed. For services on Board review concerning the compensability issue, claimant's attorney is awarded a $500 attorney fee to be paid by the SAIF Corporation.

RUBY J. STEVENS, Claimant
Peter O. Hansen, Claimant's Attorney
Brian L. Pocock, Defense Attorney

WCB 85-02649
July 6, 1987
Order on Review

Reviewed by Board Members McMurdo and Lewis.

The insurer requests review of those portions of Referee Gary Peterson's order that: (1) set aside its "de facto" denial of a reclining chair; (2) assessed a 25 percent penalty and attorney fee for the insurer's untimely denial; (3) awarded claimant 10 percent (32 degrees) unscheduled permanent disability, in addition to the 15 percent (48 degrees) unscheduled permanent disability awarded by the Determination Order; and (4) awarded claimant a $1,000 attorney fee. The issues are medical services, extent of unscheduled permanent disability, penalties and attorney fees.

We reverse that portion of the order that set aside the de facto denial of the reclining chair.

In October 1984 claimant suffered a compensable lumbosacral strain. On December 10, 1984, claimant's treating physician, Dr. Thomson, osteopath, prescribed a reclining chair for home bed rest. In the prescription, Dr. Thomson noted that the chair was necessary to elevate claimant's feet above her hips. In a follow-up report, Dr. Thomson stated that the recliner was helpful because it "positions her as an electric hospital bed might." Dr. Thomson also noted that claimant was more comfortable with her knees and hips flexed. Concluding that these reports satisfied OAR 436-10-040(7), the Referee found that the chair was a compensable medical service pursuant to ORS 656.245. We disagree.

OAR 436-10-040(7) provides:

"Furniture is not a medical service. Articles such as beds, hot tubs, chairs, jacuzzis, and gravity traction devices are not compensable unless a need is clearly

> justified by a report which establishes that the 'nature of the injury and the process of recovery requires' that the item be furnished. The report must set forth with particularity why the patient requires an item not usually considered necessary in the great majority of workers with similar impairments. . . . "

The purpose of the rule is to create reasonable conditions for the payment of benefits, consistent with ORS 656.245. See Kemp v. Worker's Comp. Dept., 65 Or App 659, 669 (1983), modified, 67 Or App 270, rev den 297 Or 227 (1984).

We conclude that Dr. Thomson's conclusory report fails to satisfy the requirements of the administrative rule in that the need for the chair is not clearly justified. Consequently, claimant has failed to establish that the chair is reasonable and necessary medical service as required by ORS 656.245.

Having found the chair noncompensable, there is no compensation then due upon which to base the award of a penalty for the insurer's failure to deny the medical services claim within 60 days. However, claimant's attorney is entitled to a reasonable attorney fee for establishing the claims processing violation. See Hutchinson v. Louisiana-Pacific Corp., 81 Or App 162, 164 (1986); Spivey v. SAIF, 79 Or App 568 (1986). We modify the amount of the attorney for services on this issue. In lieu of the Referee's award of a $250 attorney fee for this issue, we conclude that $150 is a reasonable attorney fee.

The remainder of the order is affirmed.

We find the extent issue to have been of average difficulty with an ordinary likelihood of success on Board review. A reasonable attorney fee is therefore awarded.

ORDER

The Referee's order dated October 10, 1986 is affirmed, reversed and modified. That portion of the order that found the reclining chair a compensable medical service is reversed. In lieu of the Referee's award of a $250 attorney fee for the late denial of the reclining chair, claimant is awarded $150 as a reasonable attorney fee. The remainder of the Referee's order is affirmed. Claimant's attorney is awarded $450 for services on Board review, concerning the extent issue, to be paid by the insurer.

EUGENE E. FERRIS, Claimant
Michael Bruce, Claimant's Attorney
Schwabe, et al., Defense Attorneys

WCB 84-06595
July 8, 1987
Order on Review

Reviewed by Board Members Lewis and McMurdo.

The self-insured employer requests review of Referee Podnar's order that awarded claimant 15 percent (48 degrees) unscheduled permanent disability for a low back condition, in addition to 10 percent (32 degrees) previously awarded by a Determination Order. The issue on review is extent of unscheduled permanent disability.

Claimant, 49 years of age at the hearing, sustained a compensable low back injury in March 1982. On the day of his injury, he reported to a hospital emergency room and was examined by Dr. Pollard. X-rays revealed no evidence of an acute trauma, but did show some evidence of lumbar sclerosis.

The next month, claimant was examined by his treating orthopedist, Dr. Warren. Warren diagnosed a lumbosacral strain and released claimant from work. Warren also noted evidence of bilateral spondylosis at L-5.

Claimant was next examined by the Southern Oregon Medical Consultants in June 1982. The Consultants noted defects at L-5, and opined that claimant was "mildly moderately physically impaired."

Thereafter, claimant returned to regular work with periodic work releases for recurrent exacerbations of low back pain. In October 1982, claimant was seen by Dr. Campagna, neurosurgeon. Campagna diagnosed inter alia, a nerve root compression and bilateral pars defect in the lower back. He recommended a myelogram, but claimant apparently declined surgical intervention.

In May 1983, Dr. Warren stated that claimant had "no permanent partial disability." In June 1984, Warren responded to an inquiry from claimant's attorney as follows:

> "The percent whole body permanent physical impairment and loss of physical function to [the] whole body is rated 0% [sic]. Consequently I would not be able to make a strong statement with reference to permanent disability."

One year later, Warren reiterated, "the [claimant] has essentially no permanent partial disability." Lastly, in March 1986, Warren reported that claimant was "without permanent partial disability."

In April 1986, a Determination Order awarded claimant 10 percent unscheduled permanent disability.

Claimant credibly testified that he was educated through the eighth grade. His prior employment history includes work as a horse groomer, construction laborer, and truck driver. In 1972, he began working for the employer, a sawmill. While there, he mainly worked as a forklift driver, carrier operator, and endload operator. After his compensable 1982 injury, he returned to regular work as a forklift driver. However, the prolonged sitting and jarring produced low back pain. Thus, sometime in 1984, he changed jobs and began working as an endloader. Even though "the work was heavier," claimant felt that he could tolerate endloading better than forklift driving.

Despite Dr. Warren's unwavering opinion that claimant was without permanent impairment, the Referee awarded claimant an additional 15 percent unscheduled permanent disability. We find the Referee's award excessive.

In rating the extent of claimant's unscheduled permanent partial disability for his low back, we consider his physical

impairment as reflected in the medical record and the testimony at the hearing and all of the relevant social and vocational factors set forth in OAR 436-30-380 et seq. We apply these rules as guidelines, not as restrictive mechanical formulas. Harwell v. Argonaut Insurance Co., 296 Or 505, 510 (1984).

Here, Dr. Warren, claimant's treating orthopedist, has unequivocally stated that claimant suffers no permanent impairment. The only medical opinion to the contrary is the July 1982 report from the Southern Oregon Medical Consultants. At that time, however, claimant was neither medically stationary nor released to return to regular work. Therefore, we are more persuaded by the several subsequent reports from Dr. Warren rather than the one-time 1982 report from the Consultants.

Following our de novo review of the medical evidence and claimant's credible testimony of low back pain, we find that claimant's permanent impairment is in the minimal range. Exercising our independent judgment in light of claimant's level of impairment and the relevant social and vocational factors, we conclude that an award of 10 percent (32 degrees) unscheduled permanent disability adequately and appropriately compensates claimant for the permanent loss of earning capacity due to his industrial injury.

ORDER

The Referee's order dated October 17, 1986, is reversed. The award by Determination Order is reinstated.

MILFORD W. HUFFMAN, Claimant
Kenneth D. Peterson, Claimant's Attorney
SAIF Corp Legal, Defense Attorney

Own Motion 84-0461M
July 8, 1987
Own Motion Determination on Reconsideration

On March 19, 1987, we reopened claimant's 1973 injury claim. Pursuant to our order, the SAIF Corporation was directed to pay temporary total disability compensation commencing September 15, 1986, and to continue to do so until claim closure under ORS 656.278. On May 6, 1987, the claim was closed by virtue of our Own Motion Determination. Pursuant to our determination, SAIF was ordered to pay temporary disability benefits from September 15, 1986 through January 9, 1987. In addition, claimant was awarded additional permanent disability, giving him a total of 50 percent unscheduled permanent disability. Deduction of any overpaid temporary disability benefits against these awards was also approved.

Asserting that he was unaware of SAIF's request to close his claim, claimant asks that the claim be reopened. He also seeks penalties and attorney fees for the alleged improper closure request, as well as for SAIF's failure to pay temporary disability benefits as required by our March 19, 1987 order.

SAIF states that copies of all documents not previously submitted to claimant's counsel have now been provided. These documents were forwarded to claimant's counsel on May 31, 1987 and June 18, 1987. SAIF offers no explanation for its failure to submit these reports to claimant's attorney prior to our May 6, 1987 order. In addition, SAIF acknowledges that it stopped paying temporary disability benefits effective January 9, 1987. It attributes this oversight to a change in personnel.

Following our further review of this matter, we continue to conclude that claim closure is appropriate. We also find that the effective date for closure should remain as January 9, 1987. As noted in our May 6, 1987 order, once claimant is hospitalized for surgery, claim reopening can again be considered. In fact, based on its response, SAIF is apparently prepared to voluntarily reopen the claim upon the scheduling of claimant's surgery. Furthermore, we remain persuaded that a 50 percent unscheduled permanent disability award provides appropriate compensation for claimant's compensable injury.

We next address the penalty and attorney fee issues. Temporary disability benefits are due within 14 days of any determination or litigation order directing the payment of such benefits. OAR 436-60-150(3)(e). If the insurer unreasonably delays or unreasonably refuses to pay compensation, it 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 656.262(10). Furthermore, copies of requests for own motion relief and all supporting materials should be furnished to all parties. OAR 438-12-005(1)(b). Failure to comply with claim disclosure requirements may be considered unreasonable delay or refusal under ORS 656.262(10). See Ronald Santos, 38 Van Natta 576, 578 (1986).

After conducting our review, we are persuaded that SAIF failed to continue paying temporary disability compensation until claim closure as directed by our March 19, 1987 order. This termination of benefits, effective January 9, 1987, was both unilateral and contrary to the clear dictates of a standing Board order. Such conduct will not be condoned and cannot be justified by a mere change in claims personnel. Therefore, SAIF is directed to pay claimant temporary disability compensation for the period between January 10, 1987 and May 6, 1987.

Moreover, because we consider SAIF's conduct to have been unreasonable, a penalty will be assessed against the temporary disability compensation that should have been paid between January 10, 1987 through May 6, 1987. We also find that SAIF's failure to timely provide pertinent claim documents as required by Board rules was unreasonable. Therefore, a penalty will assessed for this conduct as well.

Accordingly, SAIF is directed to pay claimant temporary total disability compensation from January 10, 1987 through May 6, 1987. Inasmuch as compliance with this directive will create an overpayment, SAIF is authorized to offset these benefits, once they are paid, against any unpaid or future awards of permanent disability. As a reasonable attorney fee concerning the temporary disability issue, claimant's attorney is awarded 25 percent of the increased compensation created by this order, not to exceed $500.

For refusing to comply with a Board order and for failing to timely provide claims information, SAIF is assessed a penalty equal to 25 percent of the temporary total disability compensation payable between January 10, 1987 and May 6, 1987. In addition, as a reasonable attorney's fee concerning the penalty issues, claimant's attorney is awarded $500, to be paid by the SAIF Corporation.

LOUIS J. SCHWARTZENBERGER, Claimant
Welch, Bruun & Green, Claimant's Attorneys
David O. Horne, Defense Attorney

WCB 85-02190
July 8, 1987
Order on Review

Reviewed by Board Members Lewis and McMurdo.

The insurer requests review of those portions of Referee St. Martin's order that: (1) set aside its denial of claimant's aggravation claim for the low back; (2) set aside its "de facto" denial of claimant's claim for psychological treatment; and (3) set aside its denial of claimant's request for surgery for the low back. The issues are compensability of the claims for aggravation, a psychological condition and medical treatment.

We affirm that portion of the Referee's order that found claimant's psychological treatment to be compensable. With regard to the Referee's findings regarding claimant's claims for aggravation and medical treatment, however, we reverse.

Claimant compensably injured his low back in May 1982. The immediate diagnosis was low back strain, although an August 1982 CT scan revealed the possibility of a disk fragment at L5-S1. A myelogram soon thereafter confirmed the latter diagnosis. Surgery was offered claimant, but he elected to continue conservative treatment. On January 3, 1983 he received a steroid injection, which was initially beneficial. When his symptoms returned, however, claimant received an injection of chymopapain, an enzyme that operates to soften a hardened disk fragment, thereby relieving nerve root irritation. Claimant experienced significant initial relief from the injection. In fact, Dr. Gritzka, the surgeon who performed it, characterized claimant's improvement as "major," in terms of the reduction of pain and radiculitis.

Claimant was found to be medically stationary on July 11, 1983. A Determination Order issued two weeks later, awarding claimant 15 percent unscheduled disability for the low back. Claimant requested a hearing and by an Opinion and Order dated May 22, 1984, the Determination Order award was affirmed. The 1984 Opinion and Order was the last arrangement of compensation.

Claimant became increasingly symptomatic during late 1984 and in January 1985 he was seen by an orthopedist, Dr. Tilson. From claimant's history and subjective complaints, Tilson surmised that the chymopapain injection might have failed. He suggested surgery as an alternative form of treatment. Following the filing of a claim for aggravation, claimant returned to Dr. Gritzka. By way of a January 23, 1985 report, Gritzka reiterated that claimant had improved following the injection of chymopapain and that further medical treatment was not necessary. Three months later, Gritzka reported that whatever was causing claimant's ongoing symptoms was probably no longer related to his original injury.

In January 1986, claimant visited Dr. Franks for the first time. Based on claimant's complaints and history, as well as a review of an MRI test, Franks suggested that claimant's 1983 chymopapain injection had failed and that the L5-S1 disk fragment continued to irritate the nerve root at that level. He suggested surgery as a means of relieving claimant's symptoms. He also suggested, however, that he would defer to Dr. Gritzka regarding the degree to which the chymopapain injection had been effective.

Dr. Gritzka testified that he had seen claimant both before and after the last arrangement of compensation. He stated that following the last arrangement, there was little in the way of physical findings to suggest neurological dysfunction. He further stated that prior to the chymopapain injection, claimant exhibited the "classic" signs of nerve root compression, but that his marked improvement following the injection suggested its beneficial effects. Gritzka also explained the process by which the chymopapain injection was performed and the means for assuring that it was properly completed. Finally, he explained that the fact that the MRI findings viewed by Dr. Franks suggested the continuing presence of an extruded disk was largely unimportant, for even following a successful chymopapain injection, the soft and benign fragment would continue to show up on imaging, despite its no longer being a cause of irritation. Based on these, and other factors, Gritzka felt that claimant had neither worsened nor was in need of further medical treatment.

The Referee found the report of Dr. Franks more persuasive than those of the treating physician, and he ordered claimant's claims for aggravation and surgery accepted. He found that the MRI scan, as interpreted by Dr. Franks, suggested an ongoing disk, resulting in a compensable worsening of claimant's condition and the need for surgery. The Referee did not discuss Dr. Gritzka's testimony regarding the differences between his interpretation of the efficacy of the chymopapain injection and that of Dr. Franks.

In order for claimant to establish a compensable aggravation, he must prove that his condition has pathologically, or at least symptomatically, worsened since the last arrangement of compensation, to the extent that he is more disabled and, thus, less able to work. ORS 656.273(1); Smith v. SAIF, 302 Or 396 (1986). In order for him to prove the compensability of his claimed medical services, he must prove that they are both reasonable and necessary as a result of his original compensable injury. ORS 656.245(1); see Wetzel v. Goodwin Bros., 50 Or App 101 (1981).

After reviewing the record, we find the discussion omitted by the Referee, i.e., the controversy regarding the effectiveness of the chymopapain injection, to be the critical factor for resolving the present dispute. First, it appears to us that unless claimant can prove that he needs surgery, he cannot establish a compensable aggravation. It does not appear that he has otherwise worsened since the last arrangement of compensation.

Second, with regard to surgery, Dr. Gritzka indicates that claimant does not need it because the chymopapain injection accomplished what surgery is designed to do, i.e., relieve the L5-S1 nerve root compression. Dr. Franks is of the opinion that surgery is still required, but his opinion is based on his impression that the prior injection failed. He has specifically deferred to Dr. Gritzka on that issue, however, and Gritzka has repeatedly indicated that the injection was a success. Thus, Dr. Franks' opinion is based on erroneous information and is of reduced value.

Dr. Gritzka's is the only remaining significant opinion, and we find it persuasive. Gritzka is the long-time treating physician and the surgeon who performed claimant's injection. For those reasons, he is in a superior position to gauge whether

claimant's condition has worsened and whether he is in need of additional medical treatment. Dr. Gritzka has answered in the negative to both inquiries. After considering the record, including claimant's testimony, Garbutt v. SAIF, 297 Or 148 (1984), we find that claimant has failed to establish her claims for aggravation or medical services.

ORDER

The Referee's order dated July 21, 1986 is reversed in part and affirmed in part. Those portions of the order that set aside the insurer's denials of claimant aggravation and medical services claims are reversed. The remainder of the Referee's order is affirmed. Claimant's attorney is awarded a fee of $500 on Board review concerning the psychological treatment issue, to be paid by the insurer.

RICHARD C. CENTENO (Deceased), Claimant
William B. Wyllie, Claimant's Attorney
Cash Perrine, Attorney
Carl M. Davis, Assistant Attorney General

WCB 86-02244
July 13, 1987
Order of Dismissal

Mary Frances West, doing business as West Tire and Alignment, the putative non-complying employer, has moved the Board for an order dismissing claimant's request for Board review on the grounds that the request was untimely filed and that copies were not timely mailed to the parties. We find that the request was timely filed. However, we conclude that a copy of the request was not timely mailed to the parties. Consequently, the motion is granted.

The Referee's order issued May 22, 1987. On June 15, 1987, claimant mailed to the Board a letter stating that "[I]f a review is necessary to further the proceedings in the Centeno case" to consider the letter as such a request. The Board received this letter on June 16, 1987. Neither an acknowledgement of service upon the parties nor a certificate of personal service by mail was provided with the letter. Also on June 15, 1987, claimant directed a letter requesting claims processing information to the SAIF Corporation. In this letter, claimant indicated that, if a hearing request was needed, SAIF should consider the letter as such a request. The Board received a copy of this letter on June 17, 1987. As with the previous letter, neither an acknowledgement of service upon the parties nor a certificate of personal service by mail was provided.

The latter June 15, 1987 letter was interpreted as a hearing request and referred to the Hearings Division for processing. The previous June 15, 1987 letter was interpreted as a request for Board review. Thereafter, a computer-generated letter acknowledging the request for Board review was mailed to the parties on June 24, 1987. This was apparently the parties' first notice of claimant's request for Board review.

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).

In Argonaut Insurance Co. v. King, 63 Or App 847, 852 (1983), the court held that "compliance with ORS 656.295 requires that statutory notice of the request for review be mailed or actual notice be received within the statutory period." In King, the request for review was timely, but copies of the request were never sent to the other parties. The "actual notice" referred to by the court was the Board's computer-generated acknowledgement letter, which the evidence established was received by the insurer more than 30 days after the Referee's order was mailed. Inasmuch as the insurer's notice of the request for review was untimely, the court found that the Board lacked jurisdiction to consider the appeal.

Here, claimant timely mailed a request for Board review of the Referee's order. However, the parties were not provided with a copy of the request for review. Moreover, the parties did not receive actual knowledge of the request within the statutorily required 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); Argonaut Insurance Co. v. King, supra.

We are mindful that SAIF, as processing agent for the non-complying employer, was aware that, in the wake of the Referee's recent order, claimant was seeking information concerning the future processing of the claim. Yet, rather than demonstrating an intention to appeal the Referee's order, claimant suggested the possibility of a further hearing request. Thus, we consider any "notice" provided in this communique to have pertained to a request for hearing. Furthermore, even if viewed as a request for Board review, such "notice" would not meet the aforementioned jurisdictional requirements. See ORS 656.289(3); 656.295(2); Argonaut Insurance Co. v. King, supra.

Accordingly, the request for Board review is dismissed.

IT IS SO ORDERED.

JOAN R. BARBAREE, Claimant
Greg O'Neill, Claimant's Attorney
SAIF Corp Legal, Defense Attorney

WCB 86-05265
July 14, 1987
Order on Review

Reviewed by Board Members Ferris and Lewis.

Claimant requests review of that portion of Referee Myers' order that upheld the SAIF Corporation's denial of her occupational disease claim relating to her low back. Claimant also requests that the Board remand the case for the admission of medical evidence generated subsequent to the hearing. SAIF has filed a motion to strike claimant's brief on the ground that it is based in substantial part on the evidence submitted by claimant in his request for remand. The issues are remand, the motion to strike and compensability.

Claimant's request for remand is denied. The evidence submitted on Board review could have been developed prior to hearing with the exercise of due diligence. See Ronald L. James, 37 Van Natta 1136, 1137 (1985). SAIF's motion to strike is granted. The Board can only consider evidence already in the record. See ORS 656.295(3) & (5). On the merits, the Board affirms and adopts the order of the Referee.

ORDER

The Referee's order dated October 17, 1986 is affirmed.

CHARLES D. BARNEY, Claimant
Peter O. Hansen, Claimant's Attorney
Mark Bronstein (SAIF), Defense Attorney
Dennis M. Hunter, Attorney

WCB 86-00377
July 14, 1987
Order on Reconsideration

On May 8, 1987, the SAIF Corporation requested that we reconsider that portion of our Order on Review dated April 30, 1987 that awarded claimant a $600 attorney fee for prevailing on Board review. SAIF contended that because claimant did not submit a brief on Board review, no attorney fee should have been awarded.

On May 19, 1987, we abated our prior order to allow sufficient time to consider SAIF's argument and claimant's response on the aforementioned issue. We have now received claimant's response.

In support of its contention, SAIF cites Les Schwab Tire v. Elmer's Pancake House, 84 Or App 425 (1987). In Les Schwab, the court affirmed the Referee's and Board's responsibility finding. In addition, the court reversed the Board's attorney fee award of $100 for "services on review."

We find the present case distinguishable. In Les Schwab, claimant had conceded that, having filed no brief at the Board level, no attorney fee should have been awarded. Here, there has been no such concession. Moreover, the issue raised in this case was not insurer responsibility. Rather, SAIF was contending that claimant's injury claim was not compensable. Thus, by affirming the Referee's compensability finding, we necessarily found that the "compensation awarded to claimant should not be disallowed or reduced." Such a conclusion would entitle claimant to a reasonable attorney fee pursuant to ORS 656.382(2).

We have previously held that ORS 656.382(2) provides for an insurer-paid attorney fee where claimant prevails over an insurer-initiated request for review. Myron W. Rencehausen, 39 Van Natta 56 (1987). Therefore, we cannot deny the award of fees in the first instance. Myron W. Rencehausen, supra. Yet, we have been delegated the authority to determine the amount of the fee. Myron W. Rencehausen, supra; Dan W. Hedrick, 38 Van Natta 208 (1986), aff'd mem 83 Or App 275 (1986). To assist us in determining the amount of a reasonable attorney fee, administrative rules have been promulgated. See OAR 438-47-000 et seq.

Here, SAIF timely filed an appellant's brief. Thereafter, claimant's request for an extension of time within which to file his respondent's brief was rejected as untimely. Consequently, claimant was prohibited from responding to the contentions raised in SAIF's brief.

Since the appeal was insurer-initiated, we continue to find that claimant was entitled to an insurer-paid attorney fee on Board review. Yet, considering the efforts expended and the results obtained on review, we find that his award of attorney fees should be modified. See OAR 438-47-010; Betty J. McMullen, 38 Van Natta 117 (1986).

Accordingly, the request for reconsideration is granted and our prior order withdrawn. On reconsideration, in lieu of our prior award of attorney fees, claimant is awarded $150 for his attorney's services on Board review. Except as modified herein, we adhere to and republish our prior order, effective this date.

IT IS SO ORDERED.

SANDRA L. BERKEY, Claimant
Brown & Tarlow, Claimant's Attorneys
SAIF Corp Legal, Defense Attorney

WCB 86-00608
July 14, 1987
Order on Review

Reviewed by Board Members Ferris and Lewis.

Claimant requests review of those portions of Referee Leahy's order that: (1) upheld a Determination Order awarding 48 degrees for 15 percent unscheduled permanent partial disability for the shoulder; and (2) denied claimant's request for penalties and attorney fees for the SAIF Corporation's alleged unreasonable failure to pay interim compensation. In addition, claimant asks that we determine from the outset whether she is entitled to such compensation. The Referee did not address that issue in his order. The issues are extent of unscheduled disability, interim compensation and penalties and attorney fees.

We affirm the Referee's order with the following supplement regarding claimant's entitlement to interim compensation. Claimant was compensably injured in December 1984. The claim was later closed with an award of unscheduled disability. On March 13, 1986, claimant's family doctor wrote a letter to SAIF requesting that the claim be reopened. Although the letter suggested the need for additional medical treatment, it was silent with regard to whether claimant was unable to work as a result of her injury. Claimant's doctor had also apparently communicated with claimant's vocational provider and, according to the provider's report, the doctor had indicated that claimant was unable to work. SAIF received a copy of the provider's report, but did not receive a copy of the doctor's communication.

Claimant asserts that the doctor's letter to SAIF, coupled with the provider's report, gave SAIF notice or knowledge of claimant's "medically verified inability to work," so as to trigger SAIF's duty to commence payment of interim compensation within 14 days thereafter. ORS 656.273(6). We disagree. The physician's only direct communication with SAIF referred only to the need for additional medical services. The remaining pertinent information came from a vocational provider who, because he or she was presumably not a physician, necessarily interpreted the doctor's report as a layperson. We do not believe that a layperson's interpretation of a medical report is sufficient to provide statutory notice of a "medically verified" inability to work. Without that notice, SAIF had no duty to begin interim compensation payments.

ORDER

The Referee's order dated October 13, 1986, as supplemented herein, is affirmed.

JACK A. BOUNDS, Claimant
Samuel A. Hall, Jr., Claimant's Attorney
E. Jay Perry, Defense Attorney
SAIF Corp Legal, Defense Attorney

WCB 84-06582, 85-14233 & 85-16020
July 14, 1987
Order on Review

Reviewed by Board Members Lewis and Ferris.

The SAIF Corporation requests review of that portion of Referee Daron's order that set aside its denial of responsibility for claimant's low back condition. The issue is responsibility.

The Board affirms the order of the Referee with the following comment. The basis of our decision is that SAIF failed to prove that claimant's work activity after the subsequent insurer came on the risk materially contributed to a worsening of his underlying condition. See Hensel Phelps Construction v. Mirich, 81 Or App 290, 293-94 (1986); Eva L. (Doner) Staley, 38 Van Natta 1280, 1281 (1986).

ORDER

The Referee's order dated November 21, 1986 is affirmed.

ROBERT W. BROCKIE, Claimant
Beers, et al., Defense Attorneys

WCB 85-06263
July 14, 1987
Order of Dismissal

The insurer has moved the Board for an order dismissing claimant's request for review on the ground that a copy of the request was not timely mailed to the parties. The motion is granted.

The Referee's order of dismissal issued May 8, 1987. Claimant's request for Board review was timely mailed on June 4, 1987. The Board received the request on June 10, 1987. Neither an acknowledgement of service upon the insurer nor a certificate of personal service by mail was provided with the request. A computer-generated letter acknowledging the request for Board review was mailed to the parties on June 10, 1987. This was the insurer's first notice of the request for review.

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).

In Argonaut Insurance Co. v. King, 63 Or App 847, 852 (1983), the court held that "compliance with ORS 656.295 requires that statutory notice of the request for review be mailed or actual notice be received within the statutory period." In King, the request for review was timely, but copies of the request were never sent to the other parties. The "actual notice" referred to by the court was the Board's computer-generated acknowledgement letter, which the evidence established was received by the insurer more than 30 days after the Referee's order was mailed. Inasmuch as the insurer's notice of the request for review was untimely, the court found that the Board lacked jurisdiction to consider the appeal.

Here, claimant timely mailed his request for Board

review of the Referee's order of dismissal. However, the insurer was not provided a copy of the request for review. Moreover, the insurer did not receive actual knowledge of the request within the statutorily required 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); Argonaut Insurance Co. v. King, supra.

We are mindful that claimant has apparently been unrepresented by counsel during these proceedings. 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. Alfred F. Puglisi, 39 Van Natta 310 (1987); Julio P. Lopez, 38 Van Natta 862 (1986).

Accordingly, the request for Board review is dismissed. However, claimant is advised that his request for relief pursuant to the Board's Own Motion authority under ORS 656.278 is not affected by this order. Consequently, the request for Own Motion relief, designated as WCB Case No. 87-0292M, currently remains under consideration. To further support his request for Own Motion relief in WCB Case No. 87-0292M, claimant is reminded to promptly provide the Board with any documentation he deems relevant.

IT IS SO ORDERED.

ROB COHEN, Claimant
Pozzi, et al., Claimant's Attorneys
Acker, Underwood, et al., Defense Attorneys

WCB 85-15458
July 14, 1987
Order on Review

Reviewed by Board Members Ferris and McMurdo.

The insurer requests review of those portions of Referee Leahy's order that awarded claimant interim compensation for the period from August 16, 1985 to October 17, 1985 and assessed a penalty of 25 percent of this compensation and an attorney fee of $350 for each of four alleged claims processing violations. Claimant cross-requests review of that portion of the order that upheld the insurer's denial of his industrial injury claim relating to his low back. The issues are compensability, interim compensation, penalties and attorney fees.

Claimant filed an 801 form on September 11, 1985 in which he asserted that on August 16, 1985 he had injured his low back in the course of his employment at a bicycle shop when he slipped and nearly fell while carrying a bicycle down a flight of stairs. The insurer issued its denial on October 17, 1985.

Claimant filed his request for hearing on December 13, 1985 and demanded disclosure by the insurer in accordance with OAR 438-07-015(2). In early March 1986, claimant's attorney wrote the Presiding Referee stating that the insurer had not complied with the disclosure request and asked the Referee to assess penalties and attorney fees against the insurer. In a letter dated March 25, 1986, the Presiding Referee replied that a few days after the date of the letter from claimant's attorney, he had received a copy of a letter from defense counsel which indicated that disclosure had been accomplished. He indicated that he would add the issues of penalties and attorney fees for the alleged

disclosure violation to those previously raised by claimant in his request for hearing.

In early June 1986, claimant's attorney again wrote the Presiding Referee stating that the insurer had not disclosed all of the documents in its possession and asked him to "strike the [insurer's] denial letter." By this time, the case had been assigned to Referee Leahy and on June 25, 1986, Referee Leahy issued an "Order to Produce" directed at the insurer. The following month, claimant's attorney wrote Referee Leahy stating that the insurer had not fully complied with the Order to Produce and requested another such order. The Referee issued a second Order to Produce on August 11, 1986 and the insurer finally provided full disclosure.

At the hearing, claimant testified that immediately after the alleged incident on the stairway, he remarked to his supervisor, "Gees, I almost killed myself coming down the stairs." He then worked the rest of his shift and went home. According to claimant, he was not scheduled to work the next day and he just "sat around and watched TV" because of the pain in his back. The day after that, the 18th, claimant's back became very stiff while taking a bath and a friend had to help him out of the bathtub. Claimant was scheduled to work the 19th, but did not report to work or contact his employer. Instead, he sought treatment from Dr. Berovic, a chiropractor. Claimant testified that the next day, the 20th, he went to the shop and informed the owners of his injury. According to claimant, the owners reacted badly to claimant's claim and abruptly terminated his employment.

Claimant's supervisor testified that he was on vacation on August 16, the date of the alleged accident, and did not return until the 20th. He also indicated, however, that as soon as he returned from vacation, claimant told him that he had hurt his back at work.

The owners of the bicycle shop testified that they received a call from claimant on August 18 in which claimant told them that he would not be to work the next day because he had hurt his back working on his girl friend's car. They indicated that they did not learn that claimant was claiming a work-related back injury until shortly before he filed his 801 form. They also indicated that they had terminated claimant's employment for poor job performance rather than because of his workers' compensation claim.

Based upon his review of the record and observation of the witnesses, the Referee concluded that claimant had not injured his back at work and upheld the insurer's compensability denial. On the interim compensation issue, the Referee found that claimant had informed the employer on August 20 that he was claiming a work-related back injury and awarded interim compensation for the period from the date of the injury (August 16) to the date of the denial (October 17). The Referee then assessed four penalties of 25 percent of the interim compensation he found owing: one for the insurer's failure to pay the interim compensation in timely fashion, another for the insurer's initial failure to disclose within the time limit set by the administrative rules, another for the insurer's failure to comply with what the Referee termed "the order of the Presiding Referee to provide documents," and another for the insurer's failure to comply with the Referee's first Order to Produce. He also ordered the insurer to pay four attorney fees of $350 each.

On Board review, the insurer argues that the Referee erred in granting claimant an award of interim compensation and, in any event, erred in assessing "quadruple penalties and attorney fees." Claimant contends that the Referee erred in upholding the compensability denial and argues in favor of the Referee on the interim compensation, penalty and attorney fee issues.

On the compensability issue, we affirm the order of the Referee. We modify or reverse on the remaining issues.

On the interim compensation issue, the insurer presents three arguments: (1) claimant was entitled to no interim compensation because he failed to establish that his claim was disabling; (2) claimant was entitled to less interim compensation because he failed to establish that his claim was disabling beyond September 9, 1985; and (3) claimant was entitled to less interim compensation because he did not establish that the employer was aware that claimant was claiming a work-related back injury before August 30, 1985.

We reject the insurer's first two arguments. On September 9, 1985, claimant's treating chiropractor, Dr. Berovic, completed a form in which he checked a box labeled "released for work." Adjacent boxes labeled "regular" and "modified" were left blank. In a report dated a few days later, a consulting chiropractor, Dr. Bussanich, indicated that claimant had been released only for modified work. Claimant denied that he was released for regular work or that he returned to work until at least the time of the denial. The insurer does not refute this. From this evidence, we find that claimant was disabled during the entire period for which the Referee awarded interim compensation.

We also reject the insurer's third argument. Claimant testified that on August 16, 1985 he told his supervisor, "Gees, I almost killed myself coming down the stairs." The supervisor testified that he was on vacation on August 16, but that claimant told him about the alleged industrial injury as soon as he returned on August 20. Based upon the testimony of claimant's supervisor, we agree with the Referee that the employer received notice or knowledge of claimant's claim on August 20, 1985. See ORS 656.005(7); 656.262(4). Regarding claimant's alleged statement to his supervisor on August 16 that he had "almost killed [him]self coming down the stairs," we conclude, even if claimant can be believed on this point, that the statement was too vague to constitute notice or knowledge of a claim. The gist of the statement was that claimant avoided rather than sustained an injury. In addition, claimant worked the remainder of his shift and, as far as the record reveals, said nothing more about the alleged accident or injury.

Although we reject the insurer's arguments and agree with the Referee's conclusion that the insurer received notice or knowledge of claimant's claim on August 20, 1985, we note that the Referee awarded interim compensation beginning August 16, 1985, the date of the alleged injury. Interim compensation is payable only from the date of notice or knowledge of the claim, not from the date of disability. ORS 656.262(4); Harold D. Ward, 37 Van Natta 606, 607, 37 Van Natta 709 (1985). The date specified by the Referee for the beginning of the interim compensation period, therefore, shall be modified from August 16 to August 20, 1985.

On the penalty issue, the insurer argues that the Referee was without legal authority to assess penalties totalling more than 25 percent of the compensation then due. We agree. ORS 656.262(10); Marlene W. Ritchie, 37 Van Natta 1088, 1097 (1985). Claimant argues that Flora I. Johnston, 38 Van Natta 920 (1986) provides such authority. In that case, however, the insurer unreasonably failed to comply with three separate orders, one issued by a Referee, another by the Board and another by the Workers' Compensation Department, which mandated the payment of the same compensation. The basis of the multiple penalties in Johnston was not the fact of multiple claims processing violations, but the fact that the compensation came due three times by virtue of the three orders.

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); Spivey v. SAIF, 79 Or App 568, 572 (1986); Wilma K. Anglin, 39 Van Natta 73, 76 (1987). We agree with the Referee that the insurer unreasonably failed to pay interim compensation in a timely fashion, unreasonably failed to comply with the disclosure requirements of OAR 438-07-015(2) and unreasonably failed to comply with Referee Leahy's first Order to Produce. The attorney fees for those violations, therefore, shall be affirmed. We reverse the attorney fee award for what the Referee termed the insurer's "refusal to comply with the Order of the Presiding Referee to provide documents." The letter from the Presiding Referee to claimant's attorney dated March 25, 1986 cannot properly be designated an "order to provide documents" and there is nothing else in the record which indicates that the Presiding Referee issued any such order.

ORDER

The Referee's order dated September 18, 1986 is affirmed in part, reversed in part and modified in part. That portion of the order that upheld the insurer's denial dated October 17, 1985 is affirmed. That portion of the order that awarded interim compensation for the period beginning August 16 and ending October 17, 1985 is modified; the beginning date is changed to August 20, 1985. Those portions of the order that assessed a penalty of 25 percent for each of three discovery violations found by the Referee are reversed. The penalty of 25 percent for the insurer's failure to pay interim compensation in timely fashion is affirmed. That portion of the order that awarded an attorney fee of $350 for what the Referee termed the insurer's "refusal to comply with the Order of the Presiding Referee to provide documents" is reversed. The other three attorney fees of $350 each are affirmed.

BARBARA D. COOK, Claimant
Pozzi, et al., Claimant's Attorneys
SAIF Corp Legal, Defense Attorney

WCB 86-05403
July 14, 1987
Order of Dismissal

The SAIF Corporation filed a request for Board review of Referee Podnar's April 14, 1987 order. Claimant has moved to dismiss the request. In response to the motion, SAIF has now withdrawn its request for review.

Accordingly, it is ordered that the request for review now pending before the Board is dismissed and the order of the

Referee is final by operation of law. Inasmuch as SAIF's request for Board review has been 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).

IT IS SO ORDERED.

STEPHEN P. CULVER, Claimant
Peter O. Hansen, Claimant's Attorney
SAIF Corp Legal, Defense Attorney

WCB 85-14425
July 14, 1987
Order on Review

Reviewed by Board Members Ferris and Lewis.

Claimant requests review of those portions of Referee Neal's order that upheld the SAIF Corporation's denial of claimant's claim for an athletic club membership and refused to assess a penalty against SAIF for its failure to accept or deny the claim in timely fashion. SAIF cross-requests review of that portion of the order that awarded claimant's attorney an insurer-paid attorney fee for its failure to make payments of temporary disability compensation in timely fashion. The issues are medical services, penalties and attorney fees.

The Board affirms the order of the Referee on the issues of medical services and penalties with the following comment on the medical services issue. We agree with the Referee that the evidence presented failed to establish compliance with OAR 436-69-301(2) (renumbered OAR 436-10-050(2), effective May 1, 1985). See Sandy J. Devereaux, 37 Van Natta 156 (1985). On the issue of attorney fees, we reverse. All of the allegedly late payments were timely by virtue of the seven-day grace period provided by OAR 436-54-310(4) (renumbered 436-60-150(4), effective May 1, 1985). See Billy A. Springs, 38 Van Natta 1475 (1986). SAIF's action, therefore, was not unreasonable and no attorney fee may be awarded. See ORS 656.262(10); 656.382(1).

ORDER

The Referee's order dated July 22, 1986 is affirmed in part and reversed in part. That portion of the order that awarded claimant's attorney a fee of $100 for late payment of temporary disability compensation is reversed. The remainder of the order is affirmed.

RUSSELL W. FEIGUM, Claimant
Doblie & Associates, Claimant's Attorneys
Tooze, et al., Defense Attorneys

WCB 84-13477
July 14, 1987
Order on Review

Reviewed by Board Members McMurdo and Ferris.

The insurer requests review of those portions of Referee Galton's order that: (1) set aside its three partial denials of claimant's claim for chiropractic treatment; (2) set aside its denial of responsibility for a consulting physician's report; (3) awarded a $1,000 attorney fee on each of the three partial denials of chiropractic treatment and a $350 attorney fee on the denial pertaining to the consulting physician's report; (4) assessed penalties on two of the partial denials of chiropractic treatment and the denial of the consulting opinion; and (5) awarded penalty-associated attorney fees totalling $1,050. The issues are the compensability of chiropractic services, payment for a consulting physician's report, and penalties and attorney fees.

Claimant compensably injured his low back in October 1982 while employed as a warehouseman. He soon sought chiropractic treatment from Dr. Berovic for both low back and cervical pain. Berovic immediately released claimant to return to work, finding by January 3, 1983 that claimant's low back symptoms had markedly improved. Claimant never lost time from work as a result of the compensable injury. He continued to regularly treat with Berovic, however, largely due to complaints of ongoing neck pain. By May 1983, he was being treated approximately two times per month.

Claimant continued to receive regular treatment throughout 1984. In November of that year, the insurer sent him to Dr. Gatterman for an independent chiropractic examination. Gatterman took claimant's history, which included a description of his four-time-per-week workout schedule. According to claimant, a normal workout included weightlifting and 200 situps on an incline board. Claimant's primary complaint was neck pain and stiffness, but Gatterman was unable to elicit objective signs of orthopedic or neurologic impairment. In her opinion, claimant was medically stationary with no permanent impairment, and further chiropractic treatment was unnecessary. In fact, Gatterman suggested that because claimant had a suspected hypermobility at one level of the cervical spine, chiropractic manipulation might be contraindicated.

Contemporaneous with Dr. Gatterman's examination, Dr. Berovic arranged to have claimant examined by Dr. Milanovich, who is also a chiropractor. Milanovich found claimant to be not medically stationary and in need of one chiropractic treatment per week.

In June 1985, claimant was examined by an Orthopedic Consultants panel of three orthopedists. Like Dr. Gatterman, the panel found claimant to be completely normal with no impairment. The panel found no need for ongoing chiropractic treatment.

Dr. Berovic then arranged for another examination, this time by Dr. Bussanich, who is also a chiropractor. Bussanich found "mild to moderate" impairment in the cervical area and mild low back impairment. While he suggested that claimant maintain his exercise program, he did not comment with regard to the need for ongoing chiropractic treatment.

On July 5, 1985, Dr. Berovic issued a report to the insurer regarding claimant's need for ongoing treatment. According to Berovic, claimant gained relief from symptoms and increased range of motion as a result of chiropractic manipulations. For the first time since he began treating claimant in late 1982, Berovic opined that claimant had permanent impairment of the cervical spine. He also suggested that the orthopedists who examined claimant were not qualified to determine whether chiropractic treatment was necessary.

The hearing was held in two parts, the first being on July 23, 1985. Claimant testified that he had no injuries before starting work with the current employer. Following the compensable injury, however, claimant did not lose time from work. He was ultimately laid off for reasons unrelated to his injury, and at the time of the hearing he was working in a light duty job as a sales representative. According to claimant, his condition had improved in that he had a "much lower pain level"

since leaving his heavy warehouseman job. Despite his improvement, claimant continued to treat with Dr. Berovic approximately once per week.

Dr. Berovic also testified during the first portion of the hearing. In his opinion, claimant has a spinal misalignment, the symptoms of which can be temporarily reduced by way of chiropractic manipulation. Berovic testified that claimant does not have a hypermobility, of which Dr. Gatterman had earlier warned, but that he does have impairment. Berovic noted, however, that between November 1982 and three weeks before the hearing, he had consistently indicated that claimant was free from impairment.

After the first portion of the hearing was completed, Dr. Gatterman was deposed. Gatterman opined that claimant would likely be unable to engage in his regular and vigorous exercise program if he had a spinal problem. She remained of the opinion that claimant had no impairment and that further chiropractic treatment would be unnecessary, if not detrimental. Dr. Logan, who was one of the Orthopedic Consultants physicians who had earlier examined claimant, was also deposed. Logan agreed that there was no further need for chiropractic treatment. He indicated that when claimant was examined, he had full range of motion, completely normal orthopedic findings, was engaged in full physical activity and was, in fact, stronger than average.

Before the second portion of the hearing, Dr. Berovic issued a report in which, based on new x-rays, he changed his mind with regard to the existence of a hypermobility at C4-5. He acknowledged the presence of the defect, but stated that he had not been manipulating that area. In a March 3, 1986 report, Dr. Logan noted that he had reviewed the same x-rays seen by Dr. Berovic, and had found them to be completely normal.

Dr. Wei, a chiropractor specializing in roentgenology, testified at the second portion of the hearing. He analyzed the x-rays seen by Drs. Berovic and Logan and found them to be normal, except for a slight hypermobility at C4-5, which Wei characterized as at the "upper limits of normal." He also indicated that the slight hypermobility seen at C4-5 was atypical from those normally seen following trauma.

The Referee found the medical evidence divided. He concluded, however, that the opinion of Dr. Berovic was most persuasive, primarily because Berovic was the long-time treating chiropractor. He accorded less weight to the opinions of Drs. Logan and Gatterman, finding Logan unpersuasive because of his views on palliative treatment, and Gatterman to be questionable.

We find the issue of claimant's entitlement to chiropractic treatment to be a close question. We conclude, however, that the treatment he is receiving is no longer reasonable or necessary. ORS 656.245(1). This is a case in which the treating doctor's status, as such, is of lesser importance than the expert analysis required to resolve the controversy at issue. See Allie v. SAIF, 79 Or App 284 (1986); Hammons v. Perini, 43 Or App 299 (1979). Thus, although Dr. Berovic's longitudinal experience with claimant is a factor, the analysis offered by the various physicians is of greater significance.

After reviewing Dr. Berovic's reports, we are not persuaded by his analysis of claimant's need for treatment. First, the medical record as a whole leaves us unpersuaded that claimant suffers from injury-related physical deficits. While Dr. Berovic states that claimant suffers from a spinal misalignment, and refers to x-ray evidence of that defect, Drs. Gatterman, Wei, Logan and two other orthopedists have reviewed the same or similar data and have found claimant to be entirely normal. They have found no orthopedic or neurological evidence of impairment and have found claimant to be of superior strength. Second, Dr. Berovic treated claimant for nearly three years without finding him to have permanent impairment. Shortly before the hearing, however, he altered his opinion, stating that claimant was permanently impaired. Third, Dr. Berovic changed his mind with regard to the presence of a C4-5 hypermobility. At the time of the first hearing, he denied that there was one. Shortly thereafter, he indicated that there was, but that he wasn't treating it. Last, claimant's condition, as evidenced by his testimony and the many medical reports, is such that it is questionable whether he requires treatment. He has never missed time from work and has always been considered medically stationary by the treating doctor. He is capable of engaging in strenuous physical exercise on a regular basis and does exercises that some consulting physicians find surprising for someone with an alleged permanent spinal deficit.

We generally defer to the treating doctor's opinion regarding the need for medical treatment, unless there are persuasive reasons not to do so. Weiland v.SAIF, 64 Or App 810 (1983). For the several reasons noted supra, we are not persuaded by Dr. Berovic's opinion, and we find the evidence to preponderate against claimant's claim for additional chiropractic services. The Referee's contrary holding in that regard will be reversed.

The Referee found two of the three partial denials issued by the insurer to have been unreasonable. He, therefore, assessed a penalty and attorney fee on each. After reviewing the two denials, we agree with the Referee that they were unreasonable in that they purported to deny all future medical services for a compensable injury. Because we have held claimant's current chiropractic treatment to be noncompensable, however, no penalties will be assessed. A reduced attorney fee for each denial, however, will be awarded. Spivey v. SAIF, 79 Or App 568 (1986); Karola Smith, 38 Van Natta 76 (1986).

The Referee also held that the insurer's denial of payment for a consulting chiropractor's report should be set aside. In addition, he found the denial to have been unreasonable, giving rise to a penalty and attorney fee. We agree with the Referee that the consulting doctor's opinion is compensable. We disagree, however, that the resulting denial was unreasonable. Our review of the circumstances surrounding the denial persuades us that the insurer had a reasonable doubt as to its liability for payment of the consulting report. See Kosanke v. SAIF, 41 Or App 17 (1979).

ORDER

The Referee's order dated April 10, 1986 is reversed in part, modified in part and affirmed in part. Those portions of the order that set aside the insurer's partial denial dated

August 16, 1985 and assessed penalties on the partial denials dated December 5, 1984 and June 11, 1985, and on the denial dated July 1, 1985, are reversed. Those portions of the order that awarded claimant a penalty-associated attorney fee of $400 on the December 5, 1984 denial and $400 on the June 11, 1985 denial are modified. In lieu of the attorney fee awards made by the Referee, claimant is awarded a penalty-associated fee of $150 on each of the two aforementioned denials. The remainder of the Referee's order is affirmed. For prevailing on the issue of the consulting chiropractor's report, claimant is awarded an attorney fee of $200 for services on Board review, to be paid by the insurer.

DARLENE M. HICKMAN, Claimant
Jerry E. Gastineau, Claimant's Attorney
Beers, Zimmerman & Rice, Defense Attorneys

WCB 86-05733
July 14, 1987
Order on Review

Reviewed by Board Members Lewis and McMurdo.

Claimant requests review of Referee Quillinan's order that: (1) upheld the insurer's "de facto" denial of her aggravation claim; (2) declined to award additional interim compensation; and (3) refused to assess a penalty and attorney fee for the insurer's failure to timely deny the claim. The issues are aggravation, interim compensation, penalties and attorney fees.

The Board affirms that portion of the Referee's order that concluded claimant had not suffered an aggravation. We also agree with the Referee's finding that claimant was not entitled to additional interim compensation or a penalty and attorney fee. However, we offer the following comments.

Claimant was examined by Dr. Coplen, chiropractor, on January 2, 1986. On April 8, 1986, Dr. Coplen sent a report to claimant's attorney indicating that claimant had experienced a material worsening of her condition. Claimant's attorney forwarded the report and a request for reopening to the insurer. The report was received by the insurer on April 21, 1986. On May 2, 1986 the insurer placed the claim in deferred status and began paying interim compensation effective April 21, 1986. Payment of interim compensation continued until the denial of the aggravation claim at hearing on October 7, 1986.

Claimant seeks interim compensation commencing with Dr. Coplen's January 2, 1986 examination. In addition, claimant asserts entitlement to a penalty and attorney fee for the insurer's failure to deny the claim within 60 days. We agree with the Referee that claimant is not entitled to additional interim compensation.

In order to be entitled to interim compensation, claimant must establish that as a result of her compensable injury she has lost time from work or has diminished earning capacity. Bono v. SAIF, 298 Or 405 (1984). Following an aggravation claim, interim compensation must be paid within 14 days of the date the employer has notice or knowledge of a medically verified inability to work as a result of the worsened condition. ORS 656.273(6).

Dr. Coplen indicated that claimant's condition had worsened in his April 8, 1986 report. This report was received by the insurer on April 21, 1986. However, the report does not provide medical verification that claimant was unable to work as a result of the alleged worsening. The first indication that

claimant was unable to work was provided by Dr. Coplen on May 29, 1986. The medical verification consists of an information form on which Dr. Coplen has checked a box stating that claimant is not released to regular work. The release from work appears to be prospective only and does not refer to the January 2, 1986 examination. Consequently, we conclude that claimant is only entitled to interim compensation from May 29, 1986.

We also agree that claimant is not entitled to a penalty for the insurer's failure to deny the claim within 60 days.

Following receipt of an aggravation claim, the employer has 60 days in which to accept or deny the claim. ORS 656.262(6). Further, a request for hearing concerning the compensability of the claim is without effect until the employer has had 60 days in which to investigate. Syphers v. K-W Logging Inc., 51 Or App 769 (1981).

The insurer had 60 days from its receipt of the April 21, 1986 report to accept or deny the claim. The claim was denied at hearing after the expiration of the 60 days. However, the insurer paid interim compensation until the time of the denial. Therefore, there was no compensation then due upon which to base the award of a penalty. EBI Companies v. Thomas, 66 Or App 105 (1983); LeRoy E. Leep, 37 Van Natta 1614 (1985).

Although there is no compensation then due for the award of a penalty, claimant's attorney is entitled to an attorney fee for establishing the claims processing violation. See Hutchinson v. Louisiana-Pacific Corp., 81 Or App 162 (1986); Spivey v. SAIF, 79 Or App 568 (1986); Wilma K. Anglin, 39 Van Natta 73 (1987). We conclude that $100 is a reasonable attorney fee for this issue.

ORDER

The Referee's order dated October 21, 1986 is reversed in part and affirmed in part. In lieu of that portion of the Referee's order that declined to award an attorney fee for the insurer's late denial, claimant is awarded $100 as a reasonable attorney fee. The remainder of the Referee's order is affirmed.

ROBERT S. LITTLETON, Claimant
Malagon & Moore, Claimant's Attorneys
Schwabe, et al., Defense Attorneys

WCB 85-04258
July 14, 1987
Order on Reconsideration

Claimant has requested reconsideration of the Board's Order on Review dated June 18, 1987. Specifically, claimant asserts that he is entitled to an attorney fee for prevailing at Board review on the self-insured employer's cross-appeal. In support of his contention, claimant cites, Teel v. Weyerhaeuser Co., 294 Or 588 (1983), and Travis v. Liberty Mutual Ins., 79 Or App 126 (1986). We disagree.

We have previously considered this issue in Richard M. Deskins, 38 Van Natta 825 (1986). In Deskins, we stated that we are bound to follow the clear and unambiguous dictates of our administrative rules. Further, our interpretation of OAR 438-47-075 has led us to conclude that a cross-appellant is not considered an initiating party for purposes of awarding attorney fees pursuant to ORS 656.382(2). See Allen Fanno, 38 Van Natta 1368 (1986). Consequently, claimant is not entitled to an attorney fee on Board review.

Accordingly, the request for reconsideration is granted and our prior order withdrawn. On reconsideration, we adhere to and republish our former order of June 18, 1987 effective this date.

IT IS SO ORDERED.

JOY S. LUCAS, Applicant
Ann Kelley, Assistant Attorney General

WCB CV-86010
March 16, 1987
Findings of Fact, Conclusions and Proposed Order (Crime Victim Act)

Pursuant to notice, a hearing was conducted and concluded by Roger C. Pearson, special hearings officer, on February 20, 1987 at Salem, Oregon. Applicant, Joy S. Lucas, was present and not represented by counsel. The Department of Justice Crime Victim Compensation Fund ("Department") was represented by Ann Kelley, Assistant Attorney General. The court reporter was Cindy Fields. The record was closed February 20, 1987.

Applicant has requested review by the Workers' Compensation Board of the Department's Findings of Fact, Conclusions and Order on Reconsideration dated October 15, 1986. 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.

FINDINGS OF FACT

On the afternoon of August 25, 1985, applicant was struck by a motor vehicle while riding her bicycle. Applicant had just departed a neighborhood tavern and was traveling on her bicycle down an alleyway. Struck from the rear, she rolled down the alleyway's slight grade and came to rest in the street. As applicant was regaining her senses, she recalls seeing a young man kneeling over her. As the man bent over her, blood from a wound on applicant's right elbow "squirted" onto his forehead. When this happened, the man got into a black van with a red stripe and drove away. The van's back window had been broken out and it did not have a rear license plate.

This incident was apparently unwitnessed. Yet, James Rogers, a friend of applicant's, was immediately at the scene and notified emergency personnel. Because of this prompt action, applicant, who is a "bleeder," did not experience further complications from her injuries.

Applicant was transported to the hospital by ambulance. According to the ambulance report, she had been struck by a moving vehicle. However, the records of the emergency crew, who were also on the scene, suggested that applicant had fallen from her bicycle. In addition, the initial report from Dr. Brenneke, applicant's treating physician, indicated that she had apparently fallen from her bicycle after hitting a car or van. The report further stated that applicant was "quite intoxicated."

Dr. Brenneke performed surgery to repair a comminuted fracture of the right elbow. Following approximately thirteen

days, applicant was discharged from the hospital. During her convalescence, she has required periodic nursing care. As a result of her injury, applicant has reduced range of motion in the right elbow and is unable to lift objects with her right arm. These limitations prevent her from performing her past work activities as a cook, nurse's aide, teacher's aide, and baby sitter.

On September 13, 1985, applicant filed a "Hit and Run" report with law enforcement officials. The report did not indicate that applicant had described the driver of the van. Rather, the report noted that the van's driver neither stopped nor talked to applicant. Applicant also furnished to the Department written statements on January 16, 1986 and April 8, 1986. As with the "Hit and Run" report, neither statement described the driver nor suggested that the driver had done anything other than immediately leave the scene after the incident.

Applicant contends that she provided the Department with a statement consistent with her testimony. Although no such statement is present in the record, Steven Welker, an investigator for the Department, testified that applicant had advised him that the driver had stopped and got out of the van. Mr. Welker further stated that he had observed the alleyway where the incident occurred. Based on applicant's description, she had been struck in the vicinity of an L-shaped corner. Mr. Welker stated that a house is located at this corner, making it a "blind" corner. In Mr. Welker's opinion, an accident could very easily happen near this corner.

To date, law enforcement officials have been unable to locate either the van or its driver. Apparently because of this lack of success, no charges have been initiated.

Applicant timely filed her claim for benefits under the Compensation of Crime Victims Act. As a result of her injury, she has incurred medical expenses in excess of the $250 statutory minimum and lost wages from baby sitting jobs.

Citing inconsistencies in the record, the Department denied the claim on August 20, 1986. The Department questioned whether applicant had been struck by a vehicle. Moreover, the Department was not persuaded that applicant had been injured as a result of an intentional or reckless act. After reconsideration, the Department concluded that applicant had indeed been struck by a vehicle. However, the Department remained unpersuaded that applicant had been injured as a result of a "compensable crime."

Based on my personal observation of the witnesses, I find that they are credible. I do not interpret the minor inconsistencies between applicant's testimony and the documentary evidence as an attempt at deception. Rather, I attribute any inconsistency to the passage of time and the natural fading of memories.

CONCLUSIONS

Pursuant to ORS 147.015, applicant is entitled to an award under the Compensation of Crime Victims Act (Act), if, among other requirements:

"(1) [She] 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).

ORS 161.085(7) defines "intentional" as an act with a conscious objective to cause the result or to engage in the conduct described. "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 that 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.

The standard of review for cases appealed to the Board under the Act is de novo on the entire record. ORS 147.155(5); Jill M. Gabriel, 35 Van Natta 1224, 1226 (1983).

Following my de novo review of the documentary and testimonial evidence, I am persuaded that applicant was struck by a motor vehicle. However, I find that she was not the victim of a compensable crime. Accordingly, I conclude that the Department's Order on Reconsideration should be affirmed.

The preponderance of the evidence fails to establish that applicant's injury was caused by an intentional, knowing, or reckless act. Rather, the record preponderates that applicant's injury was either the result of the driver's negligence or of an unfortunate accident. In either case, pursuant to the strict requirements for eligibility under the Act, such conduct does not constitute a "compensable crime." See generally, Dianna Lawton, 38 Van Natta 1543 (1986).

The evidence suggests that a "hit and run" occurred on the day in question. If proven, such an offense is punishable as a Class C felony. ORS 811.705(2). The act of leaving the scene of the accident could certainly be viewed as an intentional, knowing, or reckless act. Yet, it was not this act that resulted in applicant's injury. Instead, her injury was attributable to the collision with a motor vehicle. As discussed above, the record does not establish that this collision was an intentional, knowing, or reckless act. In fact, as Mr. Welker persuasively testified, an accident could very easily occur in the vicinity of the alleyway's "blind" L-shaped corner.

Theoretically, if the evidence had established that applicant's condition was worsened because of the driver's intentional, knowing, or reckless failure to provide assistance at the scene of the accident, the worsening could have been considered the result of a "compensable crime." However, because of Mr. Rogers' prompt action and the professional care of emergency personnel, applicant's condition was fortunately

immediately stabilized. Consequently, there was no worsening of applicant's condition resulting from the intentional, knowing, or reckless act of leaving the scene of an accident. Instead, applicant's condition was solely attributable to her accidental collision with the van. Although applicant by no means bears any responsibility, the evidence fails to establish that the conduct of the van's driver in causing this collision was either intentional, knowing, or reckless.

Applicant is to be commended for the impressive manner in which she advocated her entitlement to benefits. I fully recognize her arguments and appreciate her frustrations. Yet, the Act provides for benefits to injured victims, subject to very specific requirements. Applicant has unquestionably suffered a serious injury with significant permanent ramifications. However, her damages resulting from this injury are not the responsibility of the Crime Victims Fund because she is not a victim of a "compensable crime."

Hopefully, applicant will eventually obtain restitution for her medical expenses and lost wages. Potential channels of relief appear to lie through civil action against the van's driver, other governmental agencies, or charitable organizations. However, the statute is clear that applicant's remedy does not lie with the Compensation for Crime Victims Fund.

PROPOSED ORDER

I recommend that the Findings of Fact, Conclusions and Order on Reconsideration of the Department of Justice Crime Victim Compensation Fund dated October 15, 1986 be affirmed.

JOY S. LUCAS, Applicant
ORDER OF ABATEMENT
SEE PAGE 309

WCB CV-86010
April 14, 1987

JOY S. LUCAS, Applicant
Ann Kelley, Assistant Attorney General

WCB CV-86010
July 14, 1987
Order on Reconsideration
(Crime Victim Act)

On March 31, 1987, applicant requested reconsideration of the special hearings officer's proposed order issued March 16, 1987. Specifically, applicant expressed dissatisfaction with the special hearings officer's conclusion that she was not the victim of a "compensable crime." Applicant further stated her intention to secure legal representation.

On April 14, 1987, we abated the proposed order. Applicant was granted a period of 30 days within which to obtain legal counsel and present further argument in support of her request for reconsideration. If no additional response was received within the aforementioned period, applicant was advised that we would consider this matter based on the record and arguments as presently presented.

The 30-day period has now elapsed. No further response has been forthcoming from either applicant or a legal

representative on her behalf. Consequently, we have considered this matter based on the record and arguments as currently raised.

After conducting our review of this case, we agree with the findings and conclusions contained in the proposed order of the special hearings officer. Therefore, the proposed order is affirmed in its entirety. Accordingly, this matter is final by operation of law. ORS 147.155; OAR 438-82-050(1), (2).

IT IS SO ORDERED.

MARIO SCARINO (Deceased)
Pozzi, et al., Attorneys
Norm Cole (SAIF), Defense Attorney

WCB TP-87002
July 14, 1987
Third Party Distribution Order

The SAIF Corporation, as paying agency, has petitioned the Board for an order distributing the proceeds of a third party recovery obtained by a judgment against responsible third parties. SAIF contends that its statutory lien extends to portions of the recovery which have subsequently been designated for distribution to the decedent's adult children.

In November 1980, the deceased died of lung cancer, which has been found to be compensably related to his 1942 exposure to asbestos. The deceased was survived by his widow, Mary Ann Scarino, (hereafter claimant), and three adult children. In October 1982, claimant, as personal representative for decedent's estate, initiated a civil action against several third parties. Claimant sought damages, basing the action on theories of negligence and product liability.

In August 1986, judgment was entered for claimant in the amount of $250,000, plus costs and $10,111.71 in interest. Thereafter, claimant filed a "Ratification of Covenants and Disbursement of Funds" with the Probate Department for the Superior Court in Clark County, Washington. This document, which was signed by claimant and decedent's three grown children, described the distribution of the judgment's proceeds. According to the "Ratification," not only claimant's costs and attorney fees were deducted from the estate's judgment, but the distribution also provided for one-third of the remaining funds to be disbursed equally to the decedent's three grown children.

After further reducing this "net" figure by her one-third share as a surviving beneficiary under ORS 656.593(1)(b), claimant calculated the amount of the recovery available for SAIF's statutory lien as $64,820.57. The parties have agreed that costs actually reimbursed to claimant under the Longshoremen and Harborworkers' Compensation Act cannot be deducted from the recovery. Therefore, the amount of the recovery available for SAIF's lien, as proposed by claimant, should be $65,077.78

A conflict has arisen because SAIF contends that no portion of its lien may be reduced by payments made to the decedent's children. Specifically, SAIF requests that claimant be directed to forward an additional $32,667.49 in partial satisfaction of its $200,705.34 statutory lien. Asserting that the Board lacks jurisdiction to overturn a final order of the Probate Court in the State of Washington, claimant objects to SAIF's proposed distribution of the third party recovery.

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. However, 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. ORS 656.593(1). "Beneficiary" 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 contends that since she is the sole statutory "beneficiary," only her share of the proceeds is subject to SAIF's lien. We disagree.

In accordance with ORS 656.578, claimant, as personal representative for the decedent's estate, chose to recover damages from responsible third parties. This action subsequently culminated in a judgment for claimant, on behalf of the estate. Upon the issuance of this third party judgment, the proceeds of the judgment became subject to SAIF's statutory lien as paying agency under ORS 656.593(1).

We agree with claimant's contention that decedent's three grown children are not "beneficiaries" as defined in ORS 656.005(3). Thus, 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. Yet, the children's share of the estate cannot be calculated and distributed until SAIF's lien is applied to the third party judgment's proceeds. Furthermore, the judgment was not awarded to any particular beneficiary of the estate. Instead, the "earmarking" of the judgment's proceeds for specific beneficiaries occurred only after claimant submitted the ratification of the disbursement of funds to the probate court. By this time, SAIF's statutory lien had already attached to the third party judgment on behalf of the decedent's estate.

Contrary to claimant's assertion, we are not "overruling" a final court order from another jurisdiction. Rather, we are performing our statutory duty to resolve a dispute concerning the distribution of proceeds from a third party recovery. See ORS 656.593. Moreover, the "Ratification" does not appear to be a court order, but merely claimant's announcement of her "desire" to disburse the funds of the third party judgment pursuant to a plan of distribution. It is certainly claimant's prerogative, as the estate's personal representative, to distribute the proceeds in any fashion she deems reasonable. However, in so doing, she cannot avoid the estate's statutory obligations that have been created by her election, on the decedent's behalf, to seek damages from a third party.

Accordingly, we conclude that the proceeds of claimant's third party recovery shall be distributed as detailed in the SAIF Corporation's proposed distribution.

IT IS SO ORDERED.

VERNA BURTON-BERG, Claimant
Emmons, et al., Claimant's Attorneys
John E. Snarskis, Defense Attorney

Own Motion 86-0137M
July 16, 1987
Own Motion Order

This matter has been referred to the Board for closure pursuant to its own motion authority under ORS 656.278. We conclude that jurisdiction lies with the Evaluation Division.

Pursuant to a March 10, 1986 stipulation, the parties agreed to reopen claimant's September 7, 1978 left foot injury claim. The parties further stipulated that the "exact periods of temporary total disability benefits will be determined by the Board pursuant to ORS 656.278 at such time as the claim is ready for closure." On March 25, 1986, we issued an Own Motion Order directing the insurer to begin paying temporary total disability compensation effective upon claimant's hospitalization for left foot surgery.

Following claimant's surgery and a vocational evaluation, an authorized training program was devised. This program, which was designed to develop claimant's word processing and data entry skills, received the insurer's approval in July 1986. Thereafter, claimant began attending classes at a community college.

On December 11, 1986, Dr. Smith, claimant's treating podiatrist, concluded that her condition was medically stationary. Consequently, the insurer submitted the claim for closure pursuant to ORS 656.278. However, since claimant was actively participating in her training program, no determination was forthcoming. In March 1987, upon claimant's successful completion of her coursework, the training program ended. Thereafter, the insurer resubmitted the claim for closure.

When a worker ceases to be enrolled and actively engaged in an authorized training program, ORS 656.268(5) provides that the Evaluation Division redetermine the claim, unless the worker's condition is not medically stationary. Hanna v. SAIF, 65 Or App 649, 652 (1983). For compensable injuries sustained prior to January 1, 1974, there is no entitlement to claim reopening for payment of temporary total disability benefits. See Mary Fraley, 35 Van Natta 1107 (1983); Victor Vanderschuere, 35 Van Natta 1074 (1983). Furthermore, for these pre-1974 injuries, the Board retains jurisdiction to redetermine claims following the termination of a training program. Mary Fraley, supra. However, for compensable injuries occurring January 1, 1974 and thereafter, injured workers are entitled to have their claim reopened and, upon completion of their training program, redetermined by the Evaluation Division pursuant to ORS 656.268(5). See Wayne D. Cooper, 38 Van Natta 913, 915 (1986).

Here, in accordance with the parties' March 1986 stipulation, after claimant's condition became medically stationary, her claim was submitted for closure pursuant to ORS 656.278. Yet, since claimant was actively engaged in an authorized training program, claim closure was inappropriate. See ORS 656.268(2). Upon completion of the program, claim closure has again been requested. However, we lack jurisdiction to close the claim. Instead, pursuant to ORS 656.268(5) and the aforementioned points and authorities, jurisdiction for claim closure lies with the Evaluation Division.

Accordingly, this matter is referred to the Evaluation Division for the issuance of a Determination Order as required by ORS 656.268(5).

IT IS SO ORDERED.

JAMES G. HEIDEN, Claimant
Garry L. Kahn, Claimant's Attorney
Schwabe, et al., Defense Attorneys

WCB 86-01669
July 16, 1987
Order on Review

Reviewed by Board Members McMurdo and Lewis.

The insurer requests review of Referee Lipton's order that increased claimant's unscheduled permanent disability award for a right shoulder injury from the 25 percent (80 degrees) awarded by a Determination Order, to 75 percent (240 degrees). The issue on review is extent of unscheduled disability. We agree that the award is excessive and we modify the Referee's order.

Claimant, 62 years of age at the time of hearing, compensably injured his right shoulder in May 1985 while working as a maintenance repair engineer. An arthrogram revealed a torn rotator cuff. Consequently, claimant underwent right shoulder surgery in September 1985.

Shortly thereafter, claimant was released to light-duty work with a total restriction on use of his right arm. However, the employer had no jobs available within claimant's physical restrictions. Thus, vocational assistance was authorized and it began in October 1985. Despite claimant's cooperation, employment efforts were unsuccessful.

In January 1986, a Determination Order awarded claimant 25 percent unscheduled permanent disability.

At the time of hearing, claimant had not returned to work. However, he had lined up a potential job selling asphalt. This job was to begin in the spring.

The Referee found all witnesses credible. Claimant testified that he is a high school graduate and has worked as a maintenance repair engineer for over 20 years. He further stated that lifting a bag of groceries caused right arm pain. Claimant's vocational counselor testified that claimant was employable as a maintenance supervisor, real property manager, and apartment manager. In rebuttal, Mr. Barron Maye, claimant's vocational expert, testified that all three of the aforementioned jobs were either beyond claimant's skills or his physical limitations.

Dr. Puziss, claimant's treating orthopedist, felt that claimant was capable of only light or sedentary work. Puziss limited claimant to lifting up to 20 pounds, but placed no limits on his ability to sit, stand, or walk.

In rating the extent of unscheduled permanent disability for claimant's shoulder, we consider his physical impairment as reflected in the medical record and the testimony at hearing and all of the relevant social and vocational factors set forth in OAR 436-30-380 et seq. We apply these rules as guidelines, not as

restrictive mechanical formulas. See Harwell v. Argonaut Insurance Co., 296 Or 505, 510 (1984). Following our de novo review of the medical and lay evidence, and considering the aforementioned guidelines, we conclude that a 50 percent unscheduled disability award adequately compensates claimant for his compensable right shoulder condition.

ORDER

The Referee's order dated November 4, 1986, is modified. In lieu of the Referee's award, and in addition to the 25 percent (80 degrees) unscheduled permanent disability awarded by the Determination Order, claimant is awarded 25 percent (80 degrees), giving him a total of 50 percent (160 degrees) unscheduled permanent disability for his compensable right shoulder injury. Claimant's attorney's fees shall be adjusted accordingly.

MICHAEL J. MORENO, Claimant
Callahan, et al., Claimant's Attorneys
Mitchell, et al., Defense Attorneys
Cliff, et al., Defense Attorneys

WCB 84-06570
July 16, 1987
Order of Partial Dismissal

Redline Truck Equipment, a self-insured employer, has moved for an order dismissing Industrial Indemnity's request for Board review insofar as the request pertains to WCB Case No. 84-06570. Industrial Indemnity requested Board review of a Referee's order that set aside its denial of claimant's medical services claim for his current left thumb condition. This issue was specifically raised in WCB Case No. 86-09057.

The issues addressed in WCB Case No. 84-06570 were claimant's entitlement to an additional unscheduled permanent disability award stemming from a 1979 back injury for which Redline was responsible and Redline's entitlement to a $6,782.57 offset. These issues were settled by claimant and Redline prior to the hearing which resulted in the Referee's order. Consequently, Redline did not participate in the hearing.

Inasmuch as claimant and Redline have resolved any and all issues that were pending in WCB Case No. 84-06570, Redline requests that the request for Board review be dismissed insofar as it concerns this case. Neither claimant nor Industrial Indemnity have expressed an objection to Redline's motion.

The motion is granted. Accordingly, Industrial Indemnity's request for Board review is dismissed insofar as the request pertains to WCB Case No. 84-06570. The Board retains jurisdiction over that portion of Industrial Indemnity's request for review that pertains to WCB Case No. 86-09057.

IT IS SO ORDERED.

BELINDA J. STEELE, Claimant
Vick & Gutzler, Claimant's Attorneys
Rankin, McMurry, et al., Defense Attorneys

WCB 86-01571
July 16, 1987
Order on Review

Reviewed by Board Members Lewis and McMurdo.

Claimant requests review of those portions of Referee McCullough's order that: (1) upheld the insurer's partial denial insofar as it pertained to her cervical condition; (2) awarded five percent (16 degrees) unscheduled permanent disability for her low back condition; and (3) awarded her attorney a $400 attorney's fee for overturning the insurer's partial denial insofar as it pertained to her sacroiliac condition. The issues are compensability, extent of unscheduled disability and attorney fees. Employer has submitted no brief on Board review.

The Referee found that claimant's cervical condition was not compensable. We agree. Therefore, we affirm that portion of the Referee's order that upheld the insurer's partial denial of claimant's cervical condition.

Claimant was 23 years of age at the time of the hearing. She partially completed the 11th grade, but has no GED certificate. While still in school, she was trained and eventually certified as a nurse's aide. Thereafter, she obtained a nurse's assistant certificate after completing 80 hours of college course work and one year of volunteer work. She is also certified in cardiopulmonary resuscitation. She has worked as both a nurse's aide and assistant.

In August 1984, claimant sustained a compensable low back injury while employed as a nurse's aide. A few days later, she was seen by Dr. Gallant, internist. Gallant treated claimant conservatively and diagnosed a musculoligamentous strain. Claimant continued working for about one month and then filed an injury claim. In so doing, she reported pain in her right lower back and right arm.

In November 1984, claimant was examined by Dr. Anderson, orthopedist. Anderson diagnosed, "lumbar strain without objective evidence of neurologic deficit." Further, he was concerned about claimant's obesity and encouraged her to enroll in a weight reduction program. The insurer refused to pay for that program.

Claimant returned to regular work as a nurse's aide in November 1984. However, in January 1985, she quit her job due to a combination of emotional/family difficulties, problems performing her lifting duties, and lack of transportation. That same month, Dr. Gallant recommended a course of physical therapy, weight loss, and stress reduction. In April 1985, the insurer issued a Notice of Closure, which closed claimant's claim with an award of temporary disability only.

In September 1985, claimant began "on-call" work as a certified nurse's assistant. She worked eight to 15 hours a week. At the time of the hearing, claimant was still employed in this capacity.

In December 1985, claimant commenced treatment with Dr. Saboe, chiropractor. Saboe treated claimant for back and neck complaints. Claimant had not sought medical treatment for either her back or neck since November 1984. Saboe diagnosed cervical

sprain and left sacroiliac sprain. Later, Saboe reported that he had instructed claimant to lose weight.

In January 1986, the insurer issued a partial denial of claimant's cervical and sacroiliac conditions. In July 1986, a Determination Order affirmed the insurer's April 1985 Notice of Closure.

The Referee found that claimant was 20 percent disabled, but that she had unreasonably failed to follow medical advice to reduce her weight. Consequently, he awarded claimant only five percent unscheduled permanent disability. We affirm with the following comments.

It is the insurer's burden to prove that claimant has unreasonably failed to follow medical advice to lose weight. Nelson v. EBI Companies, 296 Or 246, 252 (1984). Here, claimant testified that no doctor prescribed a diet plan and that she contacted a dietician on her own initiative. She then began a diet plan, but had to stop because of an allergic reaction to citrus fruit. A few weeks later, she was hospitalized for ulcers. Thereafter, Dr. Anderson suggested a diet plan, but it also posed a problem for claimant's allergy. Moreover, the insurer refused to pay for the cost of the diet program. Finally, claimant testified that Dr. Saboe had never instructed her on a specific diet plan. Under such circumstances, we find that the insurer has not met its burden of proving that claimant had unreasonably failed to follow medical advice to lose weight. We find, however, that the Referee's award of unscheduled disability was adequate.

In rating the extent of claimant's unscheduled permanent disability for her low back, we consider her physical impairment as reflected in the medical record and the testimony at the hearing, as well as 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).

Dr. Saboe has neither rated claimant's impairment nor placed her on any physical restrictions. Saboe only stated that claimant had "permanent residuals." Dr. Gallant was "unable to demonstrate clear objective permanent impairment." Claimant testified that she cannot lift in excess of 50 pounds without suffering pain, she has trouble bending, and difficulty sleeping. She can walk, however, without difficulty.

Claimant is only 23 years of age. She nearly completed the 11th grade and has fulfilled 80 hours of college course work. She is certified as both a nurse's assistant and nurse's aide. She has work experience in both of the aforementioned fields. At the time of the hearing, she was employed as a certified nurse's assistant.

Following our de novo review, we conclude that claimant's low back impairment is in the minimal range. Exercising our independent judgment in light of claimant's level of impairment and the relevant social and vocational factors, we conclude that an award of five percent unscheduled permanent disability appropriately compensates claimant for her permanent loss of earning capacity due to the compensable 1984 injury. We, therefore, affirm the Referee's award.

Lastly, we consider the Referee's award of a $400 attorney's fee for claimant's attorney's services in overturning the insurer's partial denial with respect to claimant's sacroiliac condition. We modify.

In determining a proper attorney fee, we look to the efforts of the attorney and the results obtained. OAR 438-47-010(2); see also Arthur D. Roppe, 38 Van Natta 118 (1986). Exercising our independent judgment, we find an attorney fee of $800 to be appropriate in this case.

ORDER

The Referee's order dated November 6, 1986 is modified in part and affirmed in part. That portion of the Referee's order that awarded a $400 attorney fee is modified. The insurer shall pay claimant's attorney a fee of $800 in addition to, not out of, any compensation due claimant. The remainder of the Referee's order is affirmed.

MYRON C. VALENTINE, Claimant
Malagon & Moore, Claimant's Attorneys
EBI Legal, Defense Attorney

Own Motion 87-0321M
July 16, 1987
Own Motion Order on Reconsideration

The Board issued an Own Motion Order on June 5, 1987 whereby claimant's claim was reopened with temporary total disability compensation to commence the date claimant was hospitalized for the recommended surgery. Claimant has asked the Board to reconsider its order and allow benefits from May 24, 1987, the date claimant's doctor put him on modified work. Claimant states that his employer had no light duty for him and he has, therefore, been off work as a result of the doctor's restrictions. Claimant has submitted a new report from Dr. Schroeder in support of this request.

The insurer asks the Board to reconsider its position with respect to the recovering of an overpayment out of claimant's temporary total disability compensation. The insurer states that the Board has allowed such recovery in the past.

After careful consideration of the evidence, the Board declines to grant the additional relief claimant seeks. With respect to the overpayment issue raised by the insurer, the Board will not allow recovery of the overpayment from claimant's temporary total disability benefits. See Harold Bates, 38 Van Natta 992 (1986) and William J. Dale, 87-0029M (order dated July 6, 1987).

ORDER

The Board's June 5, 1987 Own Motion Order is withdrawn. As supplemented herein, we adhere to and republish our June 5, 1987 Own Motion Order in its entirety, effective this date.

JOHN LOSINGER, Claimant
Elliott Lynn, Claimant's Attorney
Tooze, et al., Defense Attorneys

WCB 82-10633
July 20, 1987
Order on Reconsideration

Since the Board issued its Order on Review dated June 24, 1987, the insurer has requested that the Board remand the case to the Hearings Division or Evaluation Division with instructions to determine the amount of temporary disability compensation the insurer overpaid pursuant to the Referee's order in connection with claimant's right shoulder condition. It seeks authorization to offset this overpayment against any compensation which becomes payable in the future relative to this claim. We treat the request as one for reconsideration.

Temporary disability compensation paid pursuant to a Referee's order may not be recovered by way of offset. ORS 656.313(2); Hutchinson v. Louisiana-Pacific Corp., 67 Or App 577, 581, rev den 297 Or 340 (1984). An administrative determination of the amount of the overpayment, therefore, would serve no purpose. Under these circumstances, the request for reconsideration is denied.

IT IS SO ORDERED.

LEROYCE D. BURGINGER, Claimant
Max Rae, Claimant's Attorney
Roberts, et al., Defense Attorneys

WCB 85-11429
July 21, 1987
Order on Review

Reviewed by Board Members McMurdo and Lewis.

Claimant requests review of those portions of Referee Myers' order that: (1) upheld the insurer's partial denial of claimant's claim for a psychological condition; and (2) upheld the Determination Order that found claimant to be medically stationary on January 28, 1986 and awarded no unscheduled permanent partial disability over that previously awarded by Determination Order and stipulation. Claimant also asks that a Form 1503 submitted to the Referee before he was divested of jurisdiction, but which was not entered into the hearing record, be made a part of the record for the purposes of review. The issues are compensability, premature closure or, in the alternative, extent of unscheduled disability, and whether claimant's exhibit should be admitted.

We affirm the Referee's order. The Form 1503 submitted by claimant was not considered by the Referee. We, therefore, lack jurisdiction to consider it on review. ORS 656.295(5); Groshong v. Montgomery Ward, 73 Or App 403 (1985). Neither do we find remand appropriate under the present circumstances. ORS 656.295(5).

ORDER

The Referee's order dated June 12, 1986 is affirmed.

DONALD L. CALL, Claimant
Pozzi, et al., Claimant's Attorneys
Schwabe, et al., Defense Attorneys

WCB 85-14240
July 21, 1987
Order on Review

Reviewed by Board Members Lewis and Ferris.

The insurer requests review of that portion of Referee Thye's order that set aside its denial of claimant's claim for an alleged injury-related left hip degenerative arthritis condition. The issue is compensability. We modify.

Claimant sustained a compensable low back strain in April 1985. According to his credible testimony, he began noticing left hip pain soon thereafter, whereas he had been asymptomatic prior to his injury. Diagnostic tests revealed a preexisting degenerative arthritis condition in the left hip.

The medical evidence is that claimant's underlying hip condition was not caused nor worsened by the compensable low back injury. We are persuaded, however, that the compensable injury made the hip condition temporarily symptomatic, as a result, claimant required medical treatment. The Referee found from the aforementioned evidence that claimant's hip condition was compensable.

In Roy L. Bier, 35 Van Natta 1825 (1983), we held that when a compensable injury makes a preexisting, underlying disease temporarily symptomatic without causing or worsening that disease, the responsible employer/insurer's liability may be limited to the effects of the temporary symptomatic increase, i.e., there is no liability for the underlying condition per se. See also Sylvia E. Vann, 38 Van Natta 1554 (1986); Sharon L. Novak, 38 Van Natta 601 (186); David F. Brainerd, 37 Van Natta 276 (1985). Bier applies to the present case. The Referee's order will, therefore, be modified to reflect the insurer's limited liability.

ORDER

The Referee's order dated September 15, 1986 is modified in part and affirmed in part. That portion of the order that set aside the insurer's denial of claimant's underlying hip condition is modified. The insurer's denial is upheld insofar as it denies responsibility for claimant's underlying degenerative hip condition. The insurer shall be responsible for the temporary symptomatic increase resulting from the compensable low back injury. The Referee's award of attorney fees at hearing is also modified. In lieu of the $1,500 awarded by the Referee for claimant's participation in overturning the insurer's denial, claimant is awarded a reasonable attorney fee of $750. For being partially successful in defending the compensability of his hip condition on Board review, claimant's attorney is awarded $250, to be paid by the insurer. The remainder of the Referee's order is affirmed.

DAVID E. CUMMINGS, Claimant
SAIF Corp Legal, Defense Attorney

WCB 86-00389
July 21, 1987
Order on Reconsideration

The Board has received a copy of a letter from claimant to the United States District Court in Portland, Oregon, in which claimant discusses aspects of the above-captioned claim. Claimant's letter follows our July 6, 1987 order, in which we dismissed his request for Board review on the ground that he had failed to mail copies of his request for review to the appropriate parties. We treat claimant's letter to the Federal District Court as a request that we reconsider our Order of Dismissal.

Claimant's request for reconsideration is granted, and we withdraw our prior order. On reconsideration, we adhere to and republish our prior order, effective this date.

IT IS SO ORDERED.

RONALD L. HEISINGER, Claimant
Vick & Gutzler, Claimant's Attorneys
Davis, Bostwick, et al., Defense Attorneys

WCB 85-08605
July 21, 1987
Order on Review

Reviewed by Board Members McMurdo and Lewis.

Claimant requests review of Referee Gary Peterson's order that upheld the insurer's denial of claimant's claim for medical services, and in doing so, held that the insurer's denial was effective as a denial of claimant's claim for aggravation. Claimant also requests review of the Referee's refusal to award interim compensation and additional unscheduled permanent partial disability over the 15 percent (48 degrees) awarded by a prior Determination Order. Last, claimant asks that we resolve an issue not addressed by the Referee, i.e., whether the insurer's denial should be set aside as it relates to claimant's claim for medical services. The issues are whether the insurer's denial was effective against claimant's claim for aggravation, the compensability of that aggravation claim, interim compensation, extent of unscheduled permanent partial disability and the compensability of claimant's claim for medical services.

We affirm those portions of the Referee's order that found the insurer's denial to be procedurally effective against claimant's claims for both medical services and aggravation, affirmed the denial of the aggravation claim, denied claimant's request for interim compensation and denied his request for additional unscheduled disability compensation. We find, however, that claimant has proved entitlement to additional palliative medical services. The Referee did not address this issue.

The most recent medical information in this record, which comes not only from claimant's treating doctor, but also from the physician who conducted an independent medical examination, suggests that claimant's current symptoms are related to his compensable injury. The record also reveals that claimant is in need of palliative treatment as a result of that injury. See Wetzel v.Goodwin Bros, 50 Or App 101 (1981). The insurer's denial specifically denied claimant's claim for additional medical treatment. To the extent that it did so, it is hereby set aside.

ORDER

The Referee's order dated October 27, 1986, as amended on November 6, 1986, is supplemented in part and affirmed in part. The Referee's order is supplemented to set aside the insurer's denial of claimant's claim for medical services. The remainder of the Referee's order is affirmed. Claimant's attorney is awarded $400 for services on Board review, to be paid by the insurer.

EMIL KORDON, Claimant
Malagon & Moore, Claimant's Attorneys
Pamela Schultz (SAIF), Defense Attorney

WCB 86-01089
July 21, 1987
Order on Reconsideration

Claimant has requested reconsideration of the Board's Order on Review dated June 30, 1987. On reconsideration, claimant asserts that he is entitled to an attorney fee for prevailing on Board review on the self-insured employer's cross-appeal on the issue of extent of disability. In support of his contention, claimant cites Teel v. Weyerhaeuser Co., 294 Or 588 (1983), and Travis v. Liberty Mutual Ins., 79 Or App 126 (1986).

We have previously considered this issue in Richard M. Deskins, 38 Van Natta 825 (1986). In Deskins, we stated that we are bound to follow the clear and unambiguous dictates of our administrative rules. Further, our interpretation of OAR 438-47-075 has led us to conclude that a cross-appellant is not considered an initiating party for purposes of awarding attorney fees pursuant to ORS 656.382(2) unless the appellant withdraws his appeal and the cross-appellant continues to go forward. See Allen Fanno, 38 Van Natta 1368 (1986). Consequently, claimant is not entitled to an attorney fee on Board review.

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

IT IS SO ORDERED.

MARIA R. PORRAS, Claimant
Olson Law Firm, Claimant's Attorney
Schwabe, et al., Defense Attorneys

WCB 84-11249
July 21, 1987
Order on Review

Reviewed by Board Members Lewis and McMurdo.

Claimant requests review of those portions of Referee Nichols' order that: (1) awarded claimant 112 degrees for 35 percent unscheduled permanent partial disability in addition to the Determination Order award of 160 degrees for 50 percent unscheduled disability, but declined to award permanent total disability; and (2) allowed the self-insured employer to convert an award of permanent partial disability awarded by way of a Determination Order, later found to have been prematurely issued, into temporary total disability payments ordered payable once the Determination Order was found to have been premature. The employer cross-requests review of that portion of the order that found claimant to have been medically stationary as of July 8, 1985. The employer asserts that claimant was stationary on June 4, 1985. The issues are extent of unscheduled disability, including permanent total disability, the conversion of permanent partial into temporary total disability compensation, and claimant's medically stationary date.

We affirm those portions of the Referee's order that awarded claimant a total of 85 percent unscheduled disability and allowed the employer to convert claimant's compensation payments from permanent partial into temporary total disability. We modify the Referee's order with regard to claimant's medically stationary date.

At the commencement of the hearing, the employer asserted that claimant was medically stationary as of July 8, 1985, based on a report issued that date by the treating physician, Dr. Mahoney. At the hearing, however, Mahoney modified his opinion and stated that in retrospect, claimant was stationary as of June 4, 1985. The Referee concluded that because the employer had asserted the July 8 date from the outset, that date would be used. On review, the employer argues that it should not be bound by its initial assertion, when subsequent evidence reflects an earlier medically stationary date.

We agree with the employer. We may make whatever disposition of this case we deem appropriate under ORS 656.295(6). Destael v. Nicolai Co., 80 Or App 596 (1986). On this record, we find that claimant was medically stationary on June 4, 1985. The Referee's order in that regard will be modified.

ORDER

The Referee's order dated April 14, 1986 is modified in part and affirmed in part. That portion of the order that found claimant medically stationary as of July 8, 1985 is modified. Claimant is hereby found to have been medically stationary as of June 4, 1985. The remainder of the Referee's order is affirmed.

DIXIE L. RASOR, Claimant
Ackerman, et al., Claimant's Attorneys
Garrett, et al., Defense Attorneys

WCB 85-08699
July 21, 1987
Order on Review

Reviewed by Board Members McMurdo and Ferris.

The self-insured employer requests review of that portion of Referee Menashe's order that awarded claimant 48 degrees for 15 percent unscheduled permanent partial disability for the neck and left shoulder. The issue is extent of unscheduled disability. The employer asks that the Referee's award be reversed.

Claimant compensably injured her left shoulder, neck and arm in December 1980, when a metal plate and speaker fell approximately seven feet from the ceiling and struck her. She did not receive medical treatment until February 1981, and missed only two weeks of work. She was employed full-time for another employer at the time of the hearing.

Although claimant continued working, she also continued to complain of ongoing neck and shoulder pain. She was seen by Dr. Hockey, a neurosurgeon, in late 1981 and by August 1982, he reported that claimant was medically stationary, neurologically intact and in need of no further treatment. Based on claimant's subjective complaints, however, Hockey reported that claimant would experience "minimal" permanent partial disability as a result of her compensable injury.

The medical record is essentially silent until April 1985 when Dr. Serbu, a neurosurgeon, reported that claimant had been seen for right-sided complaints. Claimant's compensable injury had been to the left side and all prior complaints had been referable to that area. A subsequent cervical myelogram revealed a C6-7 extradural defect and arthritic changes at C5. On April 25, 1985, a right cervical laminectomy at C6-7 was performed and, according to claimant, her right-sided complaints disappeared. A May 22, 1985 report from Dr. Serbu refers to claimant's shoulder and arm pains as "totally gone."

In September 1986 claimant was examined by Dr. Raaf, a neurosurgeon. Raaf's examination revealed no stiffness in the cervical area, full range of shoulder motion and good upper extremity strength. He diagnosed a muscle strain of the right neck, unrelated degenerative disease and an unrelated cervical disk lesion. Although Dr. Raaf stated that claimant was stationary and in need of no further medical treatment, he opined that she had "mild" permanent partial disability as a result of the compensable injury. His opinion was apparently based on claimant's subjective complaints of ongoing pain.

Claimant testified that she is not currently receiving medical treatment, although she has experienced a loss of motion and strength in the neck and shoulders. She also suffers from spells of dizziness. At the time of the hearing she was working 40 hours per week in a clerical job. Her prior employments included sales, clerical work, purchasing, and serving as a nurse's aide and dental assistant. She was 56 years of age at the time of the hearing and she had a high school diploma, as well as four terms of post-high school instruction in nursing and bookkeeping.

One of claimant's former coworkers testified that she worked alongside claimant during 1983 and 1984 and that claimant did not complain or display behavior suggestive of disability.

The Referee found claimant to be a "truthful, sincere person." He noted that she had become emotionally involved in her claim, suggesting that that might affect her ability to accurately outline her complaints to her physicians. He found Dr. Raaf to be in the best position to judge claimant's overall disability, however, and he found claimant to have suffered permanent partial disability to the extent of 15 percent of the whole person.

After reviewing the record, we are unpersuaded that claimant has incurred permanent disability. Although she testified to a myriad of complaints and disabilities, none have been borne out by objective medical testing. Her strength has always been seen as good, the range of motion in the neck and upper extremities has been full, and no treatment has been recommended since shortly after the 1980 accident occurred. Also noteworthy is the fact that claimant missed only two weeks of work following the injury, and has been able to work without apparent difficulty since that time. She has a varied employment background and above average educational preparation.

The physicians who have suggested that claimant has suffered permanent disability have apparently done so based on her subjective complaints, given the lack of objective evidence of impairment. Our comparison of the medical reports, claimant's

testimony and other pertinent facts, such as her years without medical treatment and an uninterrupted work history, makes us question the accuracy of the information claimant provided to her doctors. We believe it probable that she, perhaps unconsciously, exaggerated her complaints, or at least portrayed herself as more disabled than she is. In this case, therefore, we are more inclined to rely on the objective medical reports, which reveal virtually no impairment, than claimant's testimony and the histories given to her physicians. The preponderance of the evidence is that claimant has suffered no permanent partial disability. The Referee's award of 15 percent unscheduled disability will be reversed.

ORDER

The Referee's order dated October 29, 1986 is reversed in part and affirmed in part. That portion of the order that awarded claimant 15 percent (48 degrees) unscheduled permanent partial disability is reversed. The remainder of the order is affirmed.

DAVID ROMERO, Claimant
Charles D. Maier, Claimant's Attorney
Jeff Gerner (SAIF), Defense Attorney

WCB 85-15029
July 21, 1987
Order on Review

Reviewed by Board Members McMurdo and Lewis.

The SAIF Corporation requests review of Referee Foster's order that: (1) found that claimant's temporary disability should be calculated at a rate of $10 per hour; and (2) awarded an attorney fee for SAIF's failure to timely accept claimant's injury claim and for its improper calculation of temporary disability. The issues are temporary disability, penalties, and attorney fees.

We modify that portion of the order that found that claimant's temporary disability should be calculated at $10 per hour. Our review of the record persuades us that the temporary disability rate should be based on an hourly wage of $8.47.

The record contains three different hourly wage rates. The claim completed by the employer indicated $8.13 per hour. Yet, according to the employer's records, claimant received an hourly wage of $8.47. Finally, claimant testified that he was to be paid $10 per hour. SAIF processed the claim based on the $8.13 hourly wage rate. Relying on claimant's testimony, the Referee found that the rate of temporary disability should be based on a $10 per hour wage rate.

We recognize that in suggesting two different wage rates, the employer demonstrates a degree of confusion. However, claimant's testimony regarding this issue is no less inconsistent. Claimant testified that he worked a total of 77 hours. For this work, he claims he was paid a total of $537. Thus, based on this testimony, claimant's wage rate would have been approximately $7 per hour, rather than the $10 hourly wage he had previously stated.

After conducting our de novo review, we find the most persuasive evidence concerning claimant's wage rate to be his work record. Consequently, we conclude that his wage rate should be calculated at $8.47 per hour.

Considering the aforementioned confusion, we do not find SAIF's failure to pay temporary disability based on the correct wage rate to have been unreasonable. Therefore, we agree with the Referee that the assessment of a penalty for such conduct would not be appropriate. See ORS 656.262(10). However, because this conduct has not been found unreasonable, we reverse that portion of the Referee's order that awarded a $400 attorney fee concerning this issue.

Finally, we also agree with the Referee that SAIF failed to timely respond to the claim. See ORS 656.005(7); 656.262(6); Colvin v. Industrial Indemnity, 301 Or 743 (1986), on remand 83 Or App 73 (1986). Yet, contrary to the Referee's conclusion, we find that there was compensation "then due" upon which to base a penalty for this unreasonable conduct. See ORS 656.262(10). This compensation is composed of the difference between the amount of temporary disability claimant should have received, as based on the $8.47 hourly wage, and the amount he actually was paid.

Although this penalty issue has not been specifically addressed on Board review, we are free to make any disposition of the case that we deem appropriate. Destael v. Nicolai Company, 80 Or App 596 (1986). Accordingly, for its unreasonable delay in responding to the claim, SAIF is assessed a penalty equal to five percent of the aforementioned compensation differential, payable from October 1, 1985, the date claimant notified his foreman of the injury, to December 10, 1985, the date SAIF accepted the claim. The Referee's $100 attorney fee award concerning this issue is affirmed.

ORDER

The Referee's order dated September 16, 1986 is modified in part, reversed in part, and affirmed in part. Rather than basing claimant's temporary disability benefits on a $10 hourly wage rate, the SAIF Corporation is directed to pay such benefits based on a wage rate of $8.47 per hour. The Referee's award of a reasonable attorney fee, as based upon any increase in temporary disability compensation, shall be reduced accordingly. For an unreasonable delay in accepting or denying the claim, SAIF is assessed a penalty equal to five percent of the difference between the amount of temporary disability claimant was actually paid between October 1, 1985 and December 10, 1985 and the benefits he should have received, when based on an $8.47 hourly wage. Claimant's $400 attorney fee award for SAIF's alleged unreasonable calculation of temporary disability benefits is reversed. The remainder of the Referee's order is affirmed.

LEROY L. STONE, Claimant
Michael M. Bruce, Claimant's Attorney
Schwabe, et al., Defense Attorneys

WCB 85-06873, 84-02352 & 85-06872
July 21, 1987
Order on Review

Reviewed by Board Members Lewis and McMurdo.

The self-insured employer requests review of those portions of Referee Podnar's order that awarded claimant a total of 30 percent (96 degrees) unscheduled permanent disability in lieu of Determination Orders that awarded no permanent disability for two low back injuries. The issue is extent of unscheduled permanent disability.

We modify the Referee's order.

Prior to his back injuries, claimant sustained a severe injury to his left knee, culminating in a knee fusion. Subsequently, claimant's knee complaints and limitations combined to cause an acute, chronic low back strain. These complaints eventually resulted in a February 1983 hospitalization.

In January 1984 claimant suffered a compensable injury to his low back after being thrown to the ground by an explosion. X-rays demonstrated multiple congenital abnormalities, but no evidence of traumatic injury. Claimant was treated conservatively and released for light duty in February 1984. The low back pain continued and in April 1984 claimant began treating with Dr. Ditto, chiropractor.

In July 1984 claimant suffered a second compensable injury to his low back after falling down some stairs. X-rays and a CT scan continued to reveal only congenital abnormalities. Claimant treated conservatively with Drs. Ditto, Balme and Laubengayer. Dr. Laubengayer released claimant for regular work in September 1984.

In December 1984 Dr. Laubengayer stated that claimant's back problem was due to his congenital abnormalities, injury to his back and the abnormal gait that resulted from his knee fusion. Dr. Laubengayer concluded that the back problem probably would have resolved had not preexisting factors complicated the low back strain. In April 1985 Dr. Laubengayer noted that claimant continued to have mild problems with his low back. Stating that claimant was medically stationary, Dr. Laubengayer opined that claimant's residual back discomfort was due to his underlying congenital problem and abnormal gait.

In May 1985 a Determination Order awarded no permanent disability for the July 1984 falling incident. A second Determination Order issued in August 1985 awarding no permanent disability for the earlier January 1984 low back injury. Claimant timely appealed the Determination Orders.

In August 1985 Dr. Balme recommended back exercises and mild analgesics for periodic back discomfort. In September 1985 Dr. Laubengayer reported that claimant continued to have problems with back pain. Dr. Laubengayer concluded that even without claimant's abnormal gait, claimant's congenital anomaly combined with the injuries to his back were probably sufficient to cause his chronic back pain. The abnormal gait had caused a twisting of claimant's back, which Dr. Laubengayer stated contributed to his chronic pain. Dr. Balme agreed with this assessment of claimant.

Claimant is 38 years old with a 12th grade education. His work experience has been primarily in the lumber industry, performing a variety of heavy labor jobs. Since the knee injury, claimant has worked as a sticker layer, which involves only minimal physical activity. As a result of his back problem, claimant testified that sitting too long results in pain. He feels he can stand in one place for about 15 minutes and is unable to walk for more than a few blocks without resting. He feels he cannot lift objects weighing more than 20 pounds. Claimant worked full time as a sticker layer until suffering a recent ankle injury.

The Referee awarded claimant 30 percent unscheduled permanent disability for his low back injuries. We modify the award.

In rating the extent of claimant's permanent disability, we consider his physical impairment, which includes his credible testimony concerning his pain, physical limitations and relevant social and vocational factors set forth in OAR 436-30-380 et. seq. We do not apply these rules as rigid mechanical calculations that are determinative of the final result. Fraijo v. Fred N. Bay News Co., 59 Or App 260 (1982).

We note from the outset that claimant's two injuries to his low back were a material contributing cause of his current low back condition. Therefore, for purposes of determining the extent of disability, we attribute all of claimant's current low back condition and resulting disability to his compensable injuries. None of the physicians who examined claimant rated his physical impairment or commented on restrictions attributable to the low back injuries. Considering the medical reports that are available, in conjunction with claimant's credible testimony and the appropriate social and vocational factors, we are not persuaded claimant is entitled to 30 percent unscheduled permanent disability. Instead, we conclude that, as a result of the two compensable injuries, claimant is entitled to a total of 20 percent unscheduled permanent disability for the loss of earning capacity due to his low back condition.

ORDER

The Referee's order dated October 17, 1986 is modified. In lieu of the Referee's total award of 30 percent (96 degrees) unscheduled permanent disability for his two low back injuries, claimant is awarded 20 percent (64 degrees). Claimant's attorney's fee shall be adjusted accordingly. The remainder of the order is affirmed.

RODNEY A. VANDERLIN, Claimant
Horton & Koenig, Claimant's Attorneys
Cummins, et al., Defense Attorneys

WCB 86-03746
July 21, 1987
Order on Review

Reviewed by Board Members McMurdo and Lewis.

The self-insured employer requests review of that portion of Referee Foster's order that: (1) awarded claimant 15 percent (48 degrees) unscheduled permanent disability for his back injury, whereas a Determination Order had awarded no permanent disability; (2) assessed the employer a 15 percent penalty and $300 attorney fee for an underpayment of temporary disability; (3) awarded a $200 attorney fee for the employer's failure to timely comply with claimant's discovery requests; and (4) declined to find claimant medically stationary before April 7, 1986, which would have allowed an offset of temporary disability against the permanent disability award. The issues on review are extent of unscheduled disability, penalties, attorney fees, and offset.

We affirm those portions of the Referee's order that: (1) awarded claimant 15 percent unscheduled permanent disability; and (2) awarded an attorney fee for the employer's failure to timely comply with discovery. We reverse that portion of the Referee's order that assessed penalties and attorney fees for the employer's underpayment of temporary disability. Lastly, we modify that portion of the Referee's order that found claimant medically stationary on April 7, 1986.

Claimant, 28 years of age at the time of the hearing, compensably injured his mid-back and shoulders in August 1984. At that time, he was working as a separator operator for the employer, a sawmill. He had worked at the sawmill since graduating from high school in 1976.

Following claimant's August 1984 injury, he sought medical treatment from Dr. Kuzmitz, surgeon. Kuzmitz diagnosed thoracic back pain, shoulder bursitis and carpal tunnel syndrome. He then took claimant off work.

Claimant began to treat with Dr. Bert, orthopedist, in April 1985. Bert reported that claimant complained of pain despite minimal objective findings. Consequently, he recommended pain therapy treatment. Claimant attended the Callahan Center in July 1985. At that time, Dr. Toon, a Center physician, opined that claimant's work capacity was in the light to medium category and that he was medically stationary.

In August 1985, Dr. Bert reported that claimant was medically stationary with respect to his left shoulder only. He did not feel claimant was ready to return to regular work. In October 1985, Bert opined that claimant was "approaching a medically stationary date."

Later that month, claimant was examined by Dr. Boz. Boz was without X-rays or EMG results and was reluctant to offer a diagnosis. He did, however, suspect nerve impingement and suggested further evaluation for possible carpal tunnel release surgery.

In December 1985, Dr. Bert declared claimant medically stationary and released him to return to work with a 50-pound lifting restriction. In March 1986, Bert reiterated that claimant was medically stationary.

In May 1986, a Determination Order awarded claimant temporary disability through April 7, 1986, with no award of permanent disability.

At the hearing the parties stipulated inter alia to the following:

(1). In October 1985, the employer discovered an error in its calculation of claimant's temporary disability benefits, which amounted to an underpayment of $1,129.54. It immediately made a correction and sent claimant a check in the amount of the underpayment.

(2). Claimant requested discovery on November 14, 1985. Nothing was provided until February 16, 1986. Shortly thereafter, claimant requested further discovery. The requested information was not provided until June 23, 1986.

The Referee assessed a 15 percent penalty and $300 attorney fee for the employer's underpayment of temporary disability. We disagree with the Referee's assessment. The relevant statute is ORS 656.262(10):

> "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."

We have previously held that prompt remedial action by an insurer after discovery of an underpayment does not warrant penalties and attorney fees. Michael McKinney, 37 Van Natta 688 (1985); Richard N. Couturier, 36 Van Natta 59 (1984). Here, after discovering the underpayment of temporary disability, the employer "immediately" corrected its error and sent claimant a check in the amount of the underpayment. We interpret "immediately" to mean less than 14 days. See McKinney, supra, 37 Van Natta at 689. Under such circumstances, we do not find that the employer acted "unreasonably" under ORS 656.262(10). Consequently, no penalty or accompanying attorney fees should have been assessed.

We next consider whether claimant was entitled to a $200 attorney fee for the employer's late submission of discoverable materials. OAR 438-07-15(2) provides that failure to comply with discovery "may" be considered unreasonable delay or refusal under ORS 656.262(10). Here, the employer was informed of its underpayment of temporary disability in October 1985. As previously discussed, it immediately rectified the situation and paid claimant the entire amount of the underpayment. The employer's failure to timely provide discovery did not begin until late November 1985. Although there were no "amounts then due" at that time, claimant's attorney is nonetheless entitled to an attorney fee for establishing the disclosure violation. See Hutchinson v. Louisiana-Pacific Corp., 81 Or App 162, 164 (1986); Clay B. Shepperd, 39 Van Natta 125 (1987). But see Miller v. SAIF, 78 Or App 158, 161-62 (1986); Katie C. Holmes, 37 Van Natta 1134, 1136 (1985). We believe that an attorney fee of $200 is appropriate given the circumstances of this case.

Lastly, we turn to the question of whether the employer should be allowed an offset against any unpaid or future awards of permanent disability for its temporary disability payments made through April 7, 1986. In determining that claimant was entitled to temporary disability through April 7, 1986, the Evaluation Division apparently relied on the following statement by a vocational counselor in a report dated April 25, 1986:

> "The [claimant] was scheduled for a closing evaluation with Dr. Bert on April 7, 1985 [sic]."

The record before us contains no report from Dr. Bert, pertaining to an examination of April 7, 1986. However, the record does contain a Work Restriction Evaluation form completed by Dr. Bert on December 11, 1985. On that date, Bert opined that claimant was medically stationary and could return to an eight-hour work day. Dr. Toon had previously declared claimant medically stationary in July 1985.

In October 1985, Dr. Boz "suspected" some possible nerve impingement in claimant's shoulder, and "possibly" wanted an evaluation for a carpal tunnel release. Based on Boz's report, the Evaluation Division deferred closing claimant's claim.

We are persuaded by the opinions of Dr. Bert, claimant's treating physician, and Dr. Toon that claimant was medically stationary on December 11, 1985. We are not persuaded by the opinion of Dr. Boz, who offered no opinion on the issue of whether claimant was medically stationary. In fact, Dr. Boz was reluctant to make any "definitive statement" in October 1985. Moreover, he observed claimant on only one occasion, as opposed to the protracted period of observation and treatment by both Drs. Bert and Toon.

Therefore, we find that claimant's temporary disability benefits should have been paid only through December 11, 1985. ORS 656.268(2). Accordingly, we conclude that the employer is entitled to offset temporary disability benefits paid between December 11, 1985 and April 7, 1986, against any unpaid or future awards of permanent disability.

ORDER

The Referee's order dated October 20, 1986, is affirmed in part, reversed in part, and modified in part. That portion of the Referee's order that assessed penalties and attorney fees for the insurer's underpayment of temporary disability is reversed. That portion of the Referee's order that found claimant medically stationary on April 7, 1986 is modified to December 11, 1985. The employer is allowed an offset against any unpaid or future permanent disability awards for its payment of temporary disability benefits between December 11, 1985 and April 7, 1986. The remainder of the Referee's order is affirmed. For services on Board review concerning the extent of permanent disability issue, claimant's attorney is awarded $500, to be paid by the self-insured employer.

BRADLEY D. ANDERSON, Claimant
Mike Dye, Claimant's Attorney
John Motley (SAIF), Defense Attorney

WCB 86-00923
July 23, 1987
Order on Review

Reviewed by Board Members Lewis and McMurdo.

Claimant requests review of that portion of Referee Holtan's order that upheld the SAIF Corporation's denial of his aggravation claim for a back condition. The issue is aggravation.

We affirm the order of the Referee with the following commment.

In upholding the denial of the aggravation claim, the Referee relied in part on the reports of Dr. Buza. The Referee stated that Dr. Buza "examined claimant both before and after this alleged aggravation of October 1985." After de novo review of the entire record, we find no indication that Dr. Buza examined claimant after the alleged aggravation. However, we remain unpersuaded that claimant experienced an aggravation of his back condition.

Dr. Bolin did examine claimant before and after the alleged aggravation and could find no objective evidence of claimant's condition having worsened. Further, like the Referee, we find Dr. Leary's reports concerning the worsening unpersuasive. Dr. Leary stated that claimant had symptoms of increased pain due to his attempting to work driving a tractor.

As a result of these symptoms, Dr. Leary concluded claimant's condition had worsened. Yet Dr. Leary provided no objective medical explantion for claimant's increased pain.

Claimant's testimony also indicated he had suffered increased symptoms of pain. We recognize that increased symptoms of pain without an objective worsening can support an aggravation claim. Consolidated Freightways v. Foushee, 78 Or App 509 (1986). However, we conclude that claimant's exacerbation of symptoms was contemplated in his prior award of 40 percent unscheduled permanent disablility and does not suggest he is less able to work. Consequently, claimant has failed to establish that he has worsened since the last award or arrangement of compensation.

ORDER

The Referee's order dated June 16, 1986 is affirmed.

SHARON R. McINTOSH, Claimant
William H. Skalak, Claimant's Attorney
Schwabe, et al., Defense Attorneys

WCB 85-15274
July 23, 1987
Order on Review

Reviewed by Board Members McMurdo and Ferris.

The self-insured employer requests review of Referee Lipton's order that: (1) set aside its denial of claimant's industrial injury claim for a cervical strain; (2) and assessed a 25 percent penalty and associated attorney fee for the employer's alleged unreasonable denial. The issues are compensability, penalties and attorney fees. We reverse.

Claimant alleges that she incurred a cervical/dorsal strain on October 29, 1985, when the school bus she was driving was struck from the rear by an automobile. According to claimant, she was looking up into the rearview mirror when the accident occurred, and the impact caused her head to rock forward and to the right. She testified that the impact was not severe and that she did not immediately realize that she was injured. Within two days, however, she developed headaches and neck symptoms and she sought medical attention. Drs. Rasor and Weeks diagnosed a work-related cervical dorsal strain, by history.

Mr. Stedman, the employer's maintenance supervisor, testified that he visited the accident scene soon after the impact occurred. According to Stedman, the bus incurred no more than a few scratches and claimant told him that she was not aware there had been an impact until children on the bus so informed her.

Ms. Bolt, who was a passenger on the bus, also testified that she was unaware of the accident until someone informed her that the bus had been hit from behind. She was located approximately six rows behind the claimant at the time of impact but, according to her testimony, the accident caused no noticeable jostling inside the bus.

Ms. Speer was also a bus passenger and, like Ms. Bolt, she was approximately six seats behind claimant. She corroborated Ms. Bolt's testimony with regard to the minimal impact caused by the accident, characterizing it as merely a "little . . . jerk."

Ms. Duggan also testified. She was an assistant to the employer's driving supervisor and she interviewed claimant soon after the accident. According to Ms. Duggan, claimant indicated that she "didn't believe" there had been an accident until she left the bus to inspect the minimal damage caused by the automobile. A written statement from claimant later obtained by Ms. Duggan was silent with regard to accident-related injuries.

The medical record reveals that claimant was treated for migraine headaches and related complaints for several years prior to the bus accident. She also received treatment for depression resulting from apparent marital problems. Many of the complaints claimant expressed after the bus accident were similar to those she had related to her physicans prior to that time.

The Referee found claimant to be a credible witness. He also found Mr. Stedman and Ms. Speer to be credible. He found Ms. Bolt to be "a poor historian," however, and he did not rely on her testimony. He found the medical opinions to be "unanimous" in support of a work connection and found the claim compensable, "not only on its own merits but under the guidelines of Bradshaw v. SAIF, 69 Or App 587 (1984)."

It is claimant's burden to prove the compensability of her injuries. In order to satisfy that burden, she must persuade us that her head and neck pain arose out of and in the course of her employment, i.e., that there is both a legal and medical causal relationship between the accident and her injuries. ORS 656.005(8)(a). After reviewing the record, we are not persuaded.

Although the Referee found claimant credible, and we normally defer to a Referee's findings in that regard, see Miller v. Granite Const. Co., 28 Or App 473 (1977), he also found Mr. Stedman credible. Stedman's testimony, however, conflicts with that of claimant. Whereas claimant testified that she was very aware of a jerking movement at the time of the accident, and that the jerking caused her head to rock forward, Stedman testified that claimant stated to him following the accident that she was completely unaware of an impact until she was told of it by other bus passengers. This conflicting testimony remains unresolved and it detracts from claimant's case.

Because of the remaining testimony, including the credible statements of Ms. Speer, we find it more likely than not that the accident in which claimant was involved was not the cause of her headaches and neck pain. There is simply not enough persuasive evidence that the accident produced an impact of sufficient violence to cause a cervical strain. Rather, it appears that the accident produced little more than a negligible effect on the several passengers who testified at the hearing.

This case also differs from Bradshaw v. SAIF, supra, which was cited by the Referee. In Bradshaw the court held that where all non-work causes for a claimant's injury have been been shown not to have produced the injury, the alleged work incident will be presumed to be the cause through a process of elimination. In the present case, however, claimant had suffered from unrelated headaches and similar complaints for several years prior to her accident. We find no persuasive medical evidence eliminating these preexisting symptoms as a possible cause of claimant's current condition. Bradshaw, therefore, is not applicable.

Finally, although the medical opinions of Drs. Rasor and Weeks are that claimant's neck strain resulted from her accident, those opinions are necessarily based on claimant's history. She related to the doctors that she was "jerked forward, then back" in the accident, resulting in an onset of headaches within 48 hours. We have found, however, that claimant's bus accident did not produce the violent movements she later related. Therefore, we find that claimant's doctors were operating from an inaccurate history and that the value of their opinions is considerably lessened.

Claimant has failed to carry her burden of proof. The Referee's finding with regard to compensability, therefore, will be reversed. Consequently, the penalty and attorney fee issue is rendered moot.

ORDER

The Referee's order dated September 26, 1986 is reversed.

MANUEL PEREZ, Claimant
Vick & Gutzler, Claimant's Attorneys
SAIF Corp Legal, Defense Attorney

WCB 84-10951
July 23, 1987
Order on Review

Reviewed by Board Members Ferris and Lewis.

Claimant requests review of those portions of Referee Baker's order that upheld the SAIF Corporation's denial of claimant's aggravation claim relating to his low back and reduced his award of unscheduled permanent partial disability for his low back from the 50 percent (160 degrees) granted by Determination Order to 10 percent (32 degrees). Claimant also argues an issue on Board review not expressly decided by the Referee concerning medical services for his low back. In its brief, SAIF contends that the Board should refuse to address the medical services issue and that claimant's award of 10 percent unscheduled permanent partial disability should be eliminated. The issues are aggravation, extent of disability and medical services.

The Board affirms the order of the Referee on the aggravation and extent of disability issues. On the medical services issue, we conclude that by finding that claimant had sustained permanent impairment, the Referee set aside the medical services denial "sub silentio." The Referee's order shall be modified accordingly.

ORDER

The Referee's order dated August 28, 1986 is modified in part. That portion of SAIF's denial dated January 29, 1986 relating to medical treatment for claimant's compensable low back condition is set aside. The remainder of the Referee's order is affirmed. Claimant's attorney is awarded $500 for services at the Hearings level and $300 for services on Board review concerning the medical services issue, to be paid by the SAIF Corporation.

FRANKLIN L. BEEBE, Claimant
Malagon & Moore, Claimant's Attorneys
Cliff, et al., Defense Attorneys

WCB 85-03872
July 28, 1987
Order on Review

Reviewed by Board Members Lewis and McMurdo.

The insurer requests review of Referee McCullough's order that: (1) set aside an order of the Workers' Compensation Department which consented to the suspension of claimant's compensation; and (2) awarded claimant's attorney an insurer-paid attorney fee of $1,800. The issues are the procedural and substantive propriety of the Department's order and the propriety and amount of the attorney fee.

The Board affirms the order of the Referee on the issues relating to the Department's order suspending claimant's compensation with the following comment. The Referee concluded that the suspension of claimant's benefits was improper for two reasons. First, he found that the procedure followed by the Department in consenting to the suspension of benefits was unconstitutional in light of specific procedural requirements set forth by a plurality of the Court of Appeals in Carr v. SAIF, 65 Or App 110, 124 (1983), rev dismissed 297 Or 83 (1984). Second, he found that claimant's action in not attending the William A. Callahan Center was reasonable because it was based upon his treating doctor's recommendation that he obtain physical rehabilitation at another facility.

We disagree with the Referee's conclusion concerning the constitutionality of the procedures followed by the Department in suspending claimant's benefits. Subsequent to the date of the Referee's order, we ruled that the Hearings Division does not have authority to determine the constitutional validity of the Administrative Rules regulating suspension of benefits despite Carr. Tim R. Dugan, 38 Van Natta 929 (1986); Connell R. Cambron, 38 Van Natta 927 (1986). We agree, however, with the Referee's conclusion on the reasonableness issue. See Sarantis v. Sheraton Corp., 69 Or App 575, 577-79, petition for rev withdrawn 298 Or 151 (1984); Reef v. Willamette Industries, 65 Or App 366, 373-74 (1983), rev den 296 Or 638 (1984).

With regard to the attorney fee issue, we conclude that an attorney fee is proper but, based upon the factors set forth in Barbara A. Wheeler, 37 Van Natta 122, 123 (1985), we further conclude that the attorney fee awarded by the Referee should be reduced.

ORDER

The Referee's order dated August 30, 1985 is affirmed in part and modified in part. In lieu of the attorney fee awarded by the Referee, claimant's attorney is awarded $1,200 for services at the hearing level. The remainder of the Referee's order is affirmed for the reasons stated in this order. Claimant's attorney is awarded $600 for services on Board review, to be paid by the insurer.

RALEIGH H. BRANNON, Claimant
Welch, Bruun & Green, Claimant's Attorneys
Schwabe, et al., Defense Attorneys

WCB 86-02639
July 28, 1987
Order on Review

Reviewed by Board en banc.

The insurer requests review of Referee Fink's order that set aside its denial of claimant's occupational disease claim relating to his low back. The issue is compensability.

Claimant filed a claim in February 1986 asserting that the bending and twisting associated with his job in a plywood mill had compensably worsened a preexisting low back condition over a period of a year and a half. After our de novo review of the record, we find that claimant has failed to carry his burden of proving that his employment activity was the major contributing cause of a pathological worsening of his underlying low back condition. See Dethlefs v. Hyster Co., 295 Or 298, 309-10 (1983); Weller v. Union Carbide Corp., 288 Or 27, 35 (1979).

ORDER

The Referee's order dated October 17, 1986 is reversed. The insurer's denial dated February 14, 1986 is reinstated and upheld.

Board Member Lewis dissenting:

I respectfully dissent. Before going to work for the employer, claimant sustained a compensable back injury in the State of Washington and underwent fusion surgery. The medical record unanimously supports the conclusion that claimant's low back condition has pathologically worsened since that time and that the worsening manifested itself during the period of his most recent employment. The question is whether the major contributing cause of the worsening was the work activity or the natural degeneration of claimant's back after the surgery. While acknowledging that the case is a close one, the repetitive bending and twisting associated with claimant's work convinces me that his work activity was the major contributing cause of the worsening. I, therefore, would affirm the order of the Referee.

JOANN R. MAYES CLAUNTS, Claimant
Michael B. Dye, Claimant's Attorney
Nelson, et al., Defense Attorneys

WCB 85-12657
July 28, 1987
Order on Review

Reviewed by Board Members McMurdo and Lewis.

Claimant requests review of Referee Nichols' order, as adhered to on reconsideration, that: (1) upheld the insurer's denial of claimant's aggravation claim for the low back; and (2) refused to admit two exhibits on the grounds that they were untimely submitted by claimant. The issues are compensability and whether the exhibits excluded by the Referee should have been admitted.

We find that the exhibits excluded by the Referee should have been admitted. The administrative rule in effect at the time of the hearing provided that claimant was to submit additional

exhibits within 10 days before the hearing, or within seven days after the insurer's mailing of its exhibits packet to the Hearings Division, whichever came later. OAR 438-07-005(3)(b). In the present case, the insurer did not submit its exhibits until two days before the hearing. Thus, as claimant correctly points out on review, her obligation pursuant to the aforementioned administrative rule was never triggered because of the insurer's late submission.

The exhibits excluded by the Referee were considered on review. On the merits, we affirm the Referee's order.

ORDER

The Referee's order dated July 25, 1986, as adhered to on reconsideration on September 9, 1986, is affirmed.

RAUL A. HERRERA, Claimant
Pozzi, et al., Claimant's Attorneys
Daryll E. Klein, Defense Attorney
Acker, et al., Defense Attorneys

WCB 86-15787 & 86-15786
July 28, 1987
Order Denying Motion for Interim Order

Claimant has moved the Board for an order requiring Liberty Northwest Insurance Corporation to provide medical care and treatment pending review of a Referee's order. The Referee set aside Liberty's denial of claimant's "new injury" claim for a low back condition. Pursuant to the order, Liberty was directed to process the claim according to the Workers' Compensation Law. Liberty has requested Board review and claimant has filed a cross-request as against Crown Zellerbach, who was not found responsible for claimant's current condition.

Contending that Liberty is presently refusing to provide essential medical care and treatment, claimant requests that we require Liberty to do so. Liberty categorically denies the allegations, asserting that it is currently processing the claim as required by law. Although it states that it is paying claimant's temporary total disability compensation and has authorized the performance of requested medical services, Liberty acknowledges that it is withholding payment for the medical services pending the outcome of its appeal. In support of these actions, Liberty relies on ORS 656.313(4), which specifically excludes the payment of medical services from "compensation" that is required to be paid pending Board review or court appeal.

Following our review of this matter, we decline to grant the motion. To begin, allegations of noncompliance with a Referee's order are "question[s] concerning a claim." As such, these issues should be properly addressed to the Hearings Division. See ORS 656.283. Consequently, we have serious reservations regarding our jurisdiction to consider claimant's request in the first instance. Furthermore, assuming that we had jurisdiction, we are not persuaded that Liberty has refused to provide medical care and treatment. On the contrary, the submitted materials suggest that Liberty has authorized the performance of requested medical services. Any refusal by Liberty pertains to its payment of medical services pending the final outcome of its appeal, which is justified under ORS 656.313(4).

Accordingly, for the reasons set forth herein, the motion is denied.

IT IS SO ORDERED.

CRAIG E. HOBBS, Claimant
Malagon & Moore, Claimant's Attorneys
Charles Lisle (SAIF), Defense Attorney

WCB 86-02320
July 28, 1987
Order on Review

Reviewed by Board Members Ferris and Lewis.

Claimant requests review of Referee Gruber's order that found that the SAIF Corporation had accurately computed the rate of his temporary disability. The issue is temporary disability.

Claimant has worked for the employer since 1978. Prior to his October 1984 compensable injury, claimant was scheduled to work a regular 40-hour week at $9.48 per hour. Claimant's work record and testimony indicate that nonwork related medical problems prevented him from working two weeks in April 1984 and from early July 1984 until the beginning of September 1984. He worked only one week in October 1984 before suffering his compensable injury.

Claimant regularly worked Sundays, holidays and a shift differential for higher rates of pay. None of these "premium pay" periods were considered in determining the rate of his temporary disability. In addition to these premium pay periods, claimant also states that he worked periods of overtime substituting for other employees. This overtime was not scheduled and depended on whether other employees arrived for work following claimant's normal shift.

At hearing, claimant sought to have his unscheduled overtime and premium pay periods considered in determining the rate of his temporary disability rather than the straight eight-hour fixed rate used by SAIF. We agree with the Referee's exclusion of claimant's unscheduled overtime. However, we conclude that claimant's rate of temporary disability should have been calculated to include the Sundays, holidays and shift differential that he routinely worked.

Pursuant to OAR 436-60-020(4)(i), when overtime is regularly worked, it shall be considered in deterimining the rate of temporary disability.

SAIF concedes that the increased earnings claimant routinely received for working Sundays, holidays and for shift differential should have been considered in determining temporary disability. However, SAIF asserts that claimant's sick leave from early July to September was an "extended gap" as used in OAR 436-60-020(4)(a). Therefore, SAIF argues that claimant's weekly wage should only be calculated using the four weeks worked following his sick leave and prior to his compensable injury. We agree with the application of OAR 436-60-020(4)(a), but find that claimant's sick leave did not amount to an "extended gap."

The use of the "extended gap" for determining the rate of temporary disability is important in situations where the employment relationship between the worker and the employer is altered by the break in employment. Thus, determining what is an "extended gap" is not based solely on the length of the break in work, but must also be based on whether the gap has caused a change in the work relationship between employer and employee. Here, claimant worked numerous years for the same employer and there is no evidence that his "July to September" medical absence altered the work or wage expectations of either claimant or the

employer. Thus, claimant's sick leave was not an extended gap for purposes of determining the rate of temporary disability.

Finally, we conclude that the unscheduled overtime claimant worked for other employees should not be considered in the calculation of his rate of temporary disability. We are unable to determine from the record if the overtime claimant performed substituting for other employees was regularly worked within the meaning of OAR 436-60-020(4)(i). The only evidence indicating the amount of overtime worked is contained in claimant's work record. However, it is impossible to determine which overtime hours derive from his regularly scheduled shift and which hours are due to his substitutions for fellow employees. Therefore, the record fails to establish that claimant's unscheduled overtime should have been considered in determining his rate of temporary disability.

Accordingly, we conclude that claimant's rate of temporary disability shall be calculated using the average weekly earnings for the last 26 weeks he actually worked. See OAR 436-60-020(4)(a). This rate shall include claimant's premium pay periods. However, claimant's unscheduled overtime hours shall be excluded.

We decline to reach the issue of whether claimant is entitled to a penalty and attorney fee. Claimant raised the issue in his request for hearing, but withdrew the issue prior to the start of hearing. As a result, no evidence was presented concerning whether SAIF's actions were reasonable or unreasonable. Accordingly, we decline to address the issue of penalties and attorney fees on Board Review. See Cynthia J. Clark, 39 Van Natta 130 (1987); Peter R. Rios, 38 Van Natta 868 (1986).

ORDER

The Referee's order dated September 3, 1986 is affirmed in part and modified in part. Claimant's rate of temporary disability shall be modified to include his regularly worked premium pay periods. The remainder of the order is affirmed. Claimant's attorney is allowed 25 percent of the additional compensation granted by this order. However, the total attorney fees allowed by the Referee and the Board shall not exceed $3,000 as a reasonable attorney fee.

LEROY A. KOCIEMBA, Claimant
Bennett, et al., Claimant's Attorneys
Gretchen Wolfe (SAIF), Defense Attorney

Own Motion 87-0162M
July 28, 1987
Own Motion Order

Claimant has requested that the Board exercise its own motion authority and reopen his claim for an alleged worsening of his September 24, 1965 industrial injury. Claimant's aggravation rights have expired. The Board referred this case to the Hearings Division, directing that the Referee take evidence and make a recommendation on whether or not claimant's compensable condition has worsened and whether or not claimant should be granted compensation for temporary total disability.

Referee Shebley, on June 29, 1987, recommended to the Board that it reopen claimant's claim and provide temporary total disability benefits. He found claimant had not retired or withdrawn from the work force and, in fact, wanted to work. SAIF

opposes the payment of temporary total disability benefits, contending that claimant has not worked for almost 22 years and has not lost any wages as a result of his recent worsening.

After thorough review of the evidence, including the transcript of the hearing, the Board disagrees with the recommendation of the Referee. Cutright v. Weyerhaeuser Company, 299 Or 290 (1985), states: "A claim for temporary total disability benefits in the absence of wage loss seeks a remedy where there is no damage. Non-workers can sustain medical expenses. They cannot lose earnings." We find that after 22 years out of the work force claimant will not lose any earnings as a result of his recent exacerbation. We conclude the request for claim reopening for the payment of temporary total disability compensation should be denied.

Claimant reserved the issue of possible increased permanent disability at the hearing. Should the parties wish to submit evidence on that issue, they should do so within 20 days of receipt of this order.

IT IS SO ORDERED.

MOHSEN NADERI-NEJAD, Claimant
S. David Eves, Claimant's Attorney
Cummins, et al., Defense Attorneys
Brian L. Pocock, Defense Attorney

WCB 85-08315 & 86-02766
July 28, 1987
Order on Review

Reviewed by Board Members McMurdo and Lewis.

Western Insurance Company requests review of that portion of Referee Quillinan's order that set aside its denial of compensability and responsibility relating to claimant's mid-back condition. Aetna Insurance Company cross-requests review of that portion of the order requiring it to pay claimant's attorney an attorney fee on the ground that its denial of compensability was unreasonable. The issues are compensability, responsibility and attorney fees.

The Board affirms the order of the Referee on the compensability and responsibility issues. On the attorney fee issue raised by Aetna, we reverse. The Referee assessed an attorney fee against Aetna because at the time that Aetna issued its denial of compensability, the only medical evidence in the record, a report from claimant's treating chiropractor, supported the compensability of the claim. The Referee thus concluded that the denial was unreasonable.

We disagree. Claimant filed his claim approximately two months after his employment was terminated under less than friendly circumstances. He alleged a gradual onset of back pain at work without specific incident. The condition first became disabling while claimant was driving his private vehicle from California to Oregon. These circumstances cast sufficient doubt on the compensability of claimant's claim that Aetna's denial was not unreasonable when issued.

ORDER

The Referee's order dated November 12, 1986 is affirmed in part and reversed in part. That portion of the order that assessed an attorney fee against Aetna Insurance Company for

unreasonably denying claimant's claim is reversed. The remainder of the order is affirmed. Claimant's attorney is awarded $300 for services on Board review, to be paid by Western Insurance Company.

WILLIAM G. PAGE, Claimant
Welch, Bruun & Green, Claimant's Attorneys
Schwabe, et al., Defense Attorneys

WCB 86-02742
July 28, 1987
Order on Review

Reviewed by Board Members Ferris and McMurdo.

The insurer requests review of Referee Neal's order that set aside its de facto denial of claimant's occupational disease claim for "solvent encephalopathy" and assessed a penalty and attorney fee for the insurer's allegedly unreasonable failure to accept or deny the claim in timely fashion. The issues are compensability, penalties and attorney fees.

The Board affirms and adopts the order of the Referee on the compensability issue. With regard to the penalty and attorney fee issues, the parties indicated on the record at the beginning of the hearing that compensability was the only issue. We conclude that the Referee erred in deciding the issues of penalties and attorney fees because they were not preserved by claimant at the time of the hearing. See Cynthia J. Clark, 39 Van Natta 130 (1987).

ORDER

The Referee's order dated October 24, 1986 is affirmed in part and reversed in part. That portion of the order that awarded claimant a 25 percent penalty and his attorney an associated attorney fee of $200 is reversed. The remainder of the order is affirmed. Claimant's attorney is awarded $650 for services on Board review on the compensability issue, to be paid by the insurer.

LELAND R. SAMS, Claimant
Gary J. Susak, Claimant's Attorney
Alan Ludwick, Defense Attorney

WCB 85-06056
July 28, 1987
Order on Review

Reviewed by Board Members Lewis and McMurdo.

The SAIF Corporation requests review of that portion of Referee Fink's order that increased claimant's unscheduled permanent disability award for a hernia injury from 20 percent (64 degrees), as awarded by a Determination Order, to 60 percent (192 degrees). The issue is extent of unscheduled disability.

Claimant, 55 years of age at the time of hearing, sustained a compensable hernia injury in April 1984. A few months later, he underwent a right inguinal herniorrhaphy. In October 1984, Dr. Holocek, claimant's treating physician, declared claimant medically stationary and recommended lighter work. Specifically, Holocek advised that claimant not lift more than 25 pounds. In February 1985, Dr. Rose, a physician for Cascade Rehabilitation Counselors, restricted claimant to no lifting beyond 20 pounds.

After graduating from high school and serving in the military, claimant completed a two-year course in diesel mechanics.

Thereafter, he began working for the employer as a diesel mechanic. His duties included supervising and training other workers. Prior to his compensable injury, claimant had worked nearly 30 years for the employer.

Claimant was unable to obtain a new light-duty job with the employer. Consequently, vocational rehabilitation services were initiated. Although claimant's vocational counselor felt claimant had transferable skills related to mechanics, no employment offers were received.

In March 1985, a Determination Order awarded claimant 20 percent unscheduled permanent disability, primarily for his hernia injury.

Claimant credibly testified that he remained tender in the lower right part of his abdomen. He had no difficulty, however, with use of his arms, torso, or legs. He felt that he was capable of performing various light jobs.

Finding that claimant's "marketability" had been severely diminished, the Referee awarded claimant an additional 40 percent unscheduled permanent disability. We disagree.

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

Here, no physician has rated claimant's physical impairment. All the physicians agree, however, that claimant can return to work and occasionally lift up to 20 or 25 pounds. After reviewing the medical record, we conclude that claimant's physical impairment is in the minimal range.

Following our de novo review of the medical and lay evidence, and considering the relevant social and vocational factors, we conclude that a 20 percent unscheduled disability award adequately compensates claimant for his compensable hernia condition.

ORDER

The Referee's order dated October 29, 1986 is reversed. In lieu of the Referee's award, the 20 percent (64 degrees) unscheduled permanent disability awarded by the Determination Order is reinstated.

BEVERLY H. MANGUN WOLVERTON, Claimant
Emmons, et al., Claimant's Attorneys
Roberts, et al., Defense Attorneys

WCB 84-09997
July 28, 1987
Order on Review

Reviewed by Board Members Ferris and Lewis.

Claimant requests review of those portions of Referee Gary N. Peterson's order that rejected her request for temporary disability compensation, penalties and attorney fees relating to her claim for aggravation. In its brief on Board review, the self-insured employer argues that the Referee erred in setting aside its aggravation denial. The issues are aggravation, temporary disability compensation, penalties and attorney fees.

After the Referee issued his order, the Supreme Court issued its opinion in Smith v. SAIF, 302 Or 396 (1986). In that case, the court ruled that in order to establish a compensable aggravation, a claimant must show a change in his condition which results in increased temporary or permanent disability. 302 Or at 399-402. The Referee in this case found that claimant's condition had changed and that this change had not resulted in any additional disability. He nonetheless held that claimant had established a compensable aggravation. We agree with the Referee's findings, but his conclusion is inconsistent with the rule of Smith v. SAIF. We conclude, therefore, that claimant has failed to establish a compensable aggravation and reinstate the employer's aggravation denial. See Kevin J. Geyer, 39 Van Natta 391 (WCB Case No. 86-03642; May 19, 1987).

ORDER

The Referee's order dated September 12, 1986 is affirmed in part and reversed in part. That portion of the order that set aside the self-insured employer's aggravation denial dated July 26, 1984 is reversed. The denial is reinstated and affirmed. The remainder of the Referee's order is affirmed.

ROBERT W. ASHLEY, Claimant
David C. Force, Claimant's Attorney
Pamela Schultz (SAIF), Defense Attorney

WCB 84-10040
July 30, 1987
Order on Review

Reviewed by Board Members McMurdo and Lewis.

The SAIF Corporation requests review of that portion of Referee Brown's order that set aside its denial of claimant's occupational disease claim for an asthma condition. With his respondent's brief, claimant has submitted two medical documents composed after the date of the hearing for possible inclusion in the record. We treat these submissions as a request for remand. See Judy A. Britton, 37 Van Natta 1262 (1985). The issues are remand, the timeliness of claimant's claim and compensability.

Claimant's request for remand is denied. The documents submitted could have been obtained prior to the hearing with the exercise of due diligence. See Bernard L. Osburn, 37 Van Natta 1054, 1055 (1985), aff'd mem. 80 Or App 152 (1986). On the merits, the Board affirms the order of the Referee.

ORDER

The Referee's order dated August 14, 1986 is affirmed. Claimant's attorney is awarded $650 for services on Board review, to be paid by the SAIF Corporation.

KATHLEEN M. BUTLER-REEVES, Claimant
Pozzi, et al., Claimant's Attorneys
Mark Bronstein (SAIF), Defense Attorney

WCB 86-07474
July 30, 1987
Order on Review

Reviewed by Board Members Lewis and Ferris.

The SAIF Corporation requests review of that portion of Referee Gary Peterson's order, as adhered to on reconsideration, that: (1) set aside its denial of claimant's aggravation claim for the low back; and (2) assessed a penalty for an alleged unreasonable denial. Claimant cross-requests review, seeking an

attorney fee for prevailing on the penalty issue. The issues are aggravation, penalties and attorney fees.

We affirm the order of the Referee with the following modification.

Claimant is entitled to an attorney fee for services at hearing for prevailing on the penalty issue. ORS 656.262(10); 656.382(1). We conclude that $250 is a reasonable attorney fee.

Further, we find the aggravation issue to have been of average difficulty with an ordinary likelihood of success on Board review. A reasonable attorney fee is, therefore, awarded.

ORDER

The Referee's order dated October 10, 1986, as adhered to on reconsideration on November 7, 1986, is affirmed in part and modified in part. That portion of the Referee's order that failed to award a penalty-associated attorney fee is modified. Claimant's attorney is awarded $250 for services at hearing for prevailing on the penalty issue. The remainder of the Referee's order is affirmed. For services on Board review concerning the aggravation issue, claimant is awarded $600 as a reasonable attorney fee, to be paid by the SAIF Corporation.

MARY M. CHACARTEGUI, Claimant
Pozzi, et al., Claimant's Attorneys
Roberts, et al., Defense Attorneys

WCB 85-06991
July 30, 1987
Order on Review

Reviewed by Board Members Ferris and Lewis.

The insurer requests review of those portions of Referee Podnar's order that: (1) granted claimant an award of permanent total disability, in lieu of an award by Determination Order of 45 percent (144 degrees) unscheduled permanent partial disability for her neck and upper back; and (2) affirmed the medically stationary date established in the Determination Order. The insurer also requests that the Board admit evidence excluded by the Referee and, in connection with this request, moves that the Board listen to the tape recording of the hearing. The issues are evidence, extent of disability and the medically stationary date.

At the beginning of the hearing, claimant's attorney raised relevancy objections to a number of submissions by the insurer including Exhibits 2, 3, 4, 5, 18, 30, 31, 32 and 33. Counsel for the insurer stated that the relevance of Exhibits 2, 3, 4, 5 and 18 would be shown during cross-examination of claimant. The Referee excluded Exhibits 30, 31, 32 and 33 immediately and took the objections to Exhibits 2, 3, 4, 5 and 18 under advisement. The insurer made no reference to any of the challenged exhibits during claimant's cross-examination. Exhibits 2, 3, 4, 5 and 18 were ruled excluded by the Referee in his Opinion and Order. The insurer contends on Board review that all of the excluded exhibits should have been admitted.

Exhibits 2, 3, 4, 5 and 18 are multipage exhibits consisting of hospital records. Most of the more than 100 pages comprising these exhibits are temperature charts, barely legible or illegible nursing and physician notes, medical consent forms, intake and output reports, bodily fluid analysis reports and other hospital forms. A few pages arguably may be of some marginal

value as background materials in this extent of disability case. However, in light of the irrelevancy of most of the submitted materials, we affirm the Referee's exclusion of Exhibits 2, 3, 4, 5 and 18.

Exhibits 30, 31, 32 and 33 consist of various documents relating to a claim for Social Security disability benefits filed by claimant and rejected by the Social Security Administration. Counsel for the insurer argued that these documents were relevant to the issue of claimant's motivation to seek employment and also to the extent of claimant's disability. The Referee rejected these arguments and excluded the exhibits on the ground that a determination by the Social Security Administration was in no way binding in a workers' compensation proceeding. Although we agree with the Referee that a determination by the Social Security Administration is in no way binding in a workers' compensation proceeding, we also agree with the insurer that the documents relating to the determination do have some relevance in the present case. We conclude, therefore, that Exhibits 30, 31, 32 and 33 should have been admitted. We shall consider the exhibits in our review of the merits of this case.

During the course of the hearing, the insurer called a vocational rehabilitation counselor as a witness. At one point, the counselor began testifying about a labor market survey she had conducted the day before the hearing. Claimant's attorney objected to this testimony on the ground that a report of the survey had not been submitted as an exhibit in timely fashion. The Referee agreed and excluded the evidence. The insurer then put the testimony into the record by way of an offer of proof.

The statutes and rules relating to timely submission of evidence apply to documentary evidence, not to the testimony of live witnesses. See ORS 656.287; 656.310(2); OAR 438-07-005 to 438-07-010. The vocational counselor in this case was available for cross-examination or, if necessary, for later deposition by claimant's attorney. We conclude that the Referee erred in excluding the testimony and we will consider the testimony on review.

On the merits of the issue of extent of disability, we affirm the order of the Referee. On the issue of the medically stationary date, we modify the Referee's order. Claimant's treating neurologist, Dr. Nash, stated in a report dated June 15, 1984 that claimant had "achieved maximum medical benefit." He did suggest the possibility of further diagnostic tests, but in the following sentence he rejected this suggestion as of no material benefit to claimant. He then rated claimant's permanent impairment. None of the medical reports dated between Dr. Nash's report and the date of the Determination Order suggest that Dr. Nash's conclusions were premature. We, therefore, modify the medically stationary date to June 15, 1984.

ORDER

The Referee's order dated March 21, 1986 is reversed in part, modified in part and affirmed in part. Those portions of the order that excluded Exhibits 30, 31, 32 and 33 and the testimony of the vocational counselor regarding a labor market survey conducted the day before the hearing are reversed. That portion of the order that upheld the medically stationary date established in the Determination Order dated May 15, 1985 is

modified and the medically stationary date is determined as June 15, 1984. The remainder of the order is affirmed. Claimant's attorney is awarded $600 for services on Board review, to be paid by the insurer.

ROBERT HAMMOND, Claimant
EBI Legal, Defense Attorney

Own Motion 87-0305M
July 30, 1987
Own Motion Order

Claimant has requested that the Board exercise its own motion authority and reopen his claim for an alleged worsening of his November 14, 1980 industrial injury. Claimant's aggravation rights have expired. The insurer has indicated that it would be willing to reopen claimant's claim for the payment of temporary total disability compensation only if he was able to show that he was gainfully employed prior to the alleged aggravation. Surgery has been recommended by claimant's treating physician and authorized by the insurer.

Our evidence indicates that claimant was receiving temporary total disability compensation between May 1985 and May 1986. Subsequent to that time, vocational rehabilitation efforts were made on claimant's behalf, but the case was closed after claimant failed to cooperate fully with those efforts. Claimant has submitted an unsigned paper which indicates he received wages from C & H Automotive on April 13, April 17, April 27 and May 1, 1987. We are not persuaded that the paper allegedly from C & H Automotive is sufficient proof of employment. Even if it were, we would only have evidence that claimant worked for approximately three weeks during the last year. There is no indication claimant left his alleged employment as the result of his compensable condition. We are not persuaded that claimant has shown he has been a part of the work force prior to his recent aggravation. Cutright v. Weyerhaeuser Company, 299 Or 290 (1985). The request for own motion relief is hereby denied.

IT IS SO ORDERED.

VICKIE L. OLIVARES, Claimant
Vick & Associates, Claimant's Attorneys
Gary Wallmark (SAIF), Defense Attorney

WCB 84-10724 & 84-10725
July 30, 1987
Order on Review

Reviewed by Board Members Ferris and Lewis.

Claimant, pro se, requests review of Referee Quillinan's order that awarded 10 percent (15 degrees) scheduled permanent partial disability for her left knee and five percent (16 degrees) unscheduled permanent partial disability for her back, neck and right shoulder in lieu of a Determination Order which awarded no permanent disability. In her brief on Board review, claimant also argues an issue not raised at hearing involving the rate at which her temporary disability compensation was paid and requests that the case be remanded to the Hearings Division for a new hearing. Claimant was represented by an attorney at the hearing. The issues are remand, whether the Board should consider the issue raised by claimant on review, temporary disability compensation and extent of disability.

The Board denies claimant's request for remand, see ORS 656.295(5), and refuses to address the issue of temporary disability compensation. See Cynthia J. Clark, 39 Van Natta 130 (1987). On the merits, the Board affirms and adopts the order of the Referee.

ORDER

The Referee's order dated July 17, 1986 is affirmed.

JAMES M. PEAIS, Claimant
John DeWenter, Claimant's Attorney
E. Jay Perry, Defense Attorney

WCB 86-09021
July 30, 1987
Order on Review

Reviewed by Board Members Ferris and Lewis.

Claimant requests review of Referee Daron's order that: (1) rejected his request for temporary disability compensation for the period from June 12 through September 29, 1986; and (2) rejected his request for a penalty and attorney fee for the insurer's allegedly unreasonable termination of this compensation. The issues are temporary disability compensation, penalties and attorney fees.

Claimant broke several ribs and injured his teeth in a vehicle accident in the course of his employment as a long-haul truck driver in March 1986. In April 1986, claimant's treating dentist, Dr. Baron, reported that claimant would have to undergo the extraction of a number of teeth. The insurer authorized this procedure. In May 1986, claimant's treating orthopedist, Dr. Schachner, released him to regular work with regard to his rib injuries and the insurer terminated the payment of temporary disability compensation.

In a letter dated June 16, 1986, Dr. Baron reported that claimant had undergone the tooth extraction procedure on June 12 and then stated:

> "At this point I believe that [claimant] needs one week, or until June 19, 1986, to recuperate from this surgery. From that point on I anticipate that [claimant] will need approximately 3 to 4 months to have all treatment completed with the time depending on his rate of healing. During this period [claimant] should be available for dental appointments approximately twice per week. His jaw bones and gums will undergo constant change in contour during healing, and very frequent appointments may be necessary to make adjustments to keep his appliances comfortable. During this healing period other treatment will be performed. When satisfactory healing has occurred I will then be able to construct his permanent upper and lower partial dentures. [Claimant] will then be ready to resume a normal long haul work schedule."

After receiving a copy of this letter, the insurer issued one payment of temporary disability compensation for the period from June 12 through June 19, 1986.

After June 12, 1986, claimant had frequent appointments with Dr. Baron for adjustments of his temporary dentures and for other dental procedures. In a report dated September 11, 1986,

Dr. Baron reported that when claimant received his permanent dentures, he could be considered medically stationary from a dental perspective and "should be completely ready to resume a normal schedule." Claimant received his permanent dentures on September 29, 1986.

Claimant filed a request for hearing contending that he was entitled to temporary disability compensation for the entire period from June 12 through September 29, 1986 and requesting penalties and attorney fees for the insurer's failure to pay this compensation. At the hearing, claimant testified that at least through the early part of September 1986, he was taking pain medication for his dental condition and that Dr. Baron had told him not to drive while taking this medication. Claimant also testified that he never received the check issued by the insurer for the period from June 12 through June 19, 1986. The record contains a computer printout showing that the insurer issued the check, but does not contain a copy of the canceled check.

Claimant's supervisor testified that the only work available for claimant during the period from June 12 through September 29, 1986 was long-haul truck driving and that this work required claimant to be available on a continuous basis.

The Referee ruled that claimant was not entitled to temporary disability compensation after June 19, 1986. He reasoned that claimant's regular work was "driving a truck" and that after June 19, 1986 claimant was capable of doing so on a short-haul basis. Based upon the insurer's computer printout, the Referee found that the insurer had issued payment for the period from June 12 through June 19, 1986 and "inferred" that claimant had received the check. The Referee thus concluded that claimant was entitled to no further compensation and rejected his request for a penalty and attorney fee.

We conclude that claimant was entitled to temporary disability compensation for the entire period from June 12 through September 29, 1986. Claimant was incapable of engaging in long-haul truck driving by virtue of the treatment schedule and medication associated with his compensable dental condition. Even assuming that claimant was capable of short-haul truck driving, claimant's regular work and the only work available to him was of the long-haul variety. Dr. Baron did not release him for his regular work until September 29, 1986. The insurer should not have discontinued payment of temporary disability compensation before that date.

On the penalty and attorney fee issues, we conclude that the insurer unreasonably refused and resisted payment of compensation for the period from June 20 through September 29, 1986. Under the circumstances of this case, however, we do not find this refusal and resistance so unreasonable as to warrant a full 25 percent penalty. We conclude that a 10 percent penalty is appropriate as well as the associated attorney fee provided below.

ORDER

The Referee's order dated October 30, 1986 is reversed. Claimant is awarded temporary total disability compensation for the period from June 12 through September 29, 1986. Claimant's attorney is awarded 25 percent of this compensation, not to exceed $3,000, as an attorney fee. The insurer is assessed a penalty of

10 percent of the compensation due for the period from June 20 through September 29, 1986. Claimant's attorney is awarded an attorney fee of $250 on the penalty issue, to be paid by the insurer.

LOUIS J. SCHWARTZENBERGER, Claimant
Welch, Bruun & Green, Claimant's Attorneys
David O. Horne, Defense Attorney

WCB 85-02190
July 30, 1987
Order on Reconsideration

The insurer has requested reconsideration of our Order on Review dated July 8, 1987. Our order reversed those portions of the Referee's order that set aside the insurer's denials of aggravation and medical services, but affirmed his finding that claimant's treatment for a psycholgical condition is compensable. The Referee awarded an attorney fee of $2,500 for services at hearing. Specifically, the insurer asserts that we failed to delineate what portion of the attorney fees awarded by the Referee was to be allocated with regard to the issue on which claimant prevailed on Board review.

The insurer's request for reconsideration is granted and our prior order is withdrawn. On reconsideration, we note that the insurer's point is well-taken and that our order should have specified the amount of hearing-related attorney fees to be retained by claimant for prevailing on the issue of his psychological treatment.

Now, therefore, having granted the insurer's request for reconsideration, we modify our prior order. The order portion of our order shall read:

> "The Referee's order dated July 21, 1987 is reversed in part and affirmed in part. Those portions of the order that set aside the insurer's denials of claimant's aggravation and medical services claims are reversed. The remainder of the Referee's order is affirmed. In lieu of the Referee's award of attorney fees at hearing, claimant's attorney is awarded $700 for services at hearing and $500 for services on Board review concerning the psychological treatment issue. Both fees shall be paid by the insurer."

Except as modified herein, we adhere to and republish our prior order, effective this date.

IT IS SO ORDERED.

MARVIN L. SIMS, Claimant
Coons & Cole, Claimant's Attorneys
Keith Skelton, Defense Attorney

Own Motion 84-0322M
July 30, 1987
Own Motion Order and Determination on Reconsideration

The Board issued an order on May 29, 1987 whereby claimant's claim was reopened and simultaneously closed with compensation paid from February 18, 1984 through January 23, 1985 and from March 7, 1986 through June 24, 1986. Claimant has requested that the Board reconsider its order, contending claimant's claim was prematurely closed and/or he is entitled to compensation for permanent total disability. The insurer asks the Board to affirm its May 29, 1987 order.

After thorough review of the medical evidence, we are persuaded that claimant's claim was prematurely closed. We conclude our May 29, 1987 order should be withdrawn in its entirety. Claimant is hereby granted compensation for temporary total disability from February 18, 1984 through January 23, 1985 and from March 7, 1986 and continuing until closure pursuant to ORS 656.278. These benefits shall be reduced by any wages and social security benefits claimant received during the aforementioned periods. Also, amounts paid as a result of the May 29, 1987 order may be offset. Claimant's attorney is awarded 25% of the additional compensation granted by this order, not to exceed $450 as a reasonable attorney's fee.

IT IS SO ORDERED.

BELINDA J. STEELE, Claimant
Vick & Gutzler, Claimant's Attorneys
Rankin, McMurry, et al., Defense Attorneys

WCB 86-01571
July 30, 1987
Corrected Order on Review

Reviewed by Board Members Lewis and McMurdo.

Claimant requests review of those portions of Referee McCullough's order that: (1) upheld the insurer's partial denial insofar as it pertained to her cervical condition; (2) awarded five percent (16 degrees) unscheduled permanent disability for her low back condition; and (3) awarded her attorney a $400 attorney's fee for overturning the insurer's partial denial insofar as it pertained to her sacroiliac condition. The issues are compensability, extent of unscheduled disability and attorney fees. No briefs were submitted on Board review.

The Referee found that claimant's cervical condition was not compensable. We agree. Therefore, we affirm that portion of the Referee's order that upheld the insurer's partial denial of claimant's cervical condition.

Claimant was 23 years of age at the time of the hearing. She partially completed the 11th grade, but has no GED certificate. While still in school, she was trained and eventually certified as a nurse's aide. Thereafter, she obtained a nurse's assistant certificate after completing 80 hours of college course work and one year of volunteer work. She is also certified in cardiopulmonary resuscitation. She has worked as both a nurse's aide and assistant.

In August 1984, claimant sustained a compensable low back injury while employed as a nurse's aide. A few days later, she was seen by Dr. Gallant, internist. Gallant treated claimant conservatively and diagnosed a musculoligamentous strain. Claimant continued working for about one month and then filed an injury claim. In so doing, she reported pain in her right lower back and right arm.

In November 1984, claimant was examined by Dr. Anderson, orthopedist. Anderson diagnosed, "lumbar strain without objective evidence of neurologic deficit." Further, he was concerned about claimant's obesity and encouraged her to enroll in a weight reduction program. The insurer refused to pay for that program.

Claimant returned to regular work as a nurse's aide in November 1984. However, in January 1985, she quit her job due to

a combination of emotional/family difficulties, problems performing her lifting duties, and lack of transportation. That same month, Dr. Gallant recommended a course of physical therapy, weight loss, and stress reduction. In April 1985, the insurer issued a Notice of Closure, which closed claimant's claim with an award of temporary disability only.

In September 1985, claimant began "on-call" work as a certified nurse's assistant. She worked eight to 15 hours a week. At the time of the hearing, claimant was still employed in this capacity.

In December 1985, claimant commenced treatment with Dr. Saboe, chiropractor. Saboe treated claimant for back and neck complaints. Claimant had not sought medical treatment for either her back or neck since November 1984. Saboe diagnosed cervical sprain and left sacroiliac sprain. Later, Saboe reported that he had instructed claimant to lose weight.

In January 1986, the insurer issued a partial denial of claimant's cervical and sacroiliac conditions. In July 1986, a Determination Order affirmed the insurer's April 1985 Notice of Closure.

The Referee found that claimant was 20 percent disabled, but that she had unreasonably failed to follow medical advice to reduce her weight. Consequently, he awarded claimant only five percent unscheduled permanent disability. We affirm with the following comments.

It is the insurer's burden to prove that claimant has unreasonably failed to follow medical advice to lose weight. Nelson v. EBI Companies, 296 Or 246, 252 (1984). Here, claimant testified that no doctor prescribed a diet plan and that she contacted a dietician on her own initiative. She then began a diet plan, but had to stop because of an allergic reaction to citrus fruit. A few weeks later, she was hospitalized for ulcers. Thereafter, Dr. Anderson suggested a diet plan, but it also posed a problem for claimant's allergy. Moreover, the insurer refused to pay for the cost of the diet program. Finally, claimant testified that Dr. Saboe had never instructed her on a specific diet plan. Under such circumstances, we find that the insurer has not met its burden of proving that claimant had unreasonably failed to follow medical advice to lose weight. We find, however, that the Referee's award of unscheduled disability was adequate.

In rating the extent of claimant's unscheduled permanent disability for her low back, we consider her physical impairment as reflected in the medical record and the testimony at the hearing, as well as 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).

Dr. Saboe has neither rated claimant's impairment nor placed her on any physical restrictions. Saboe only stated that claimant had "permanent residuals." Dr. Gallant was "unable to demonstrate clear objective permanent impairment." Claimant

testified that she cannot lift in excess of 50 pounds without suffering pain, she has trouble bending, and difficulty sleeping. She can walk, however, without difficulty.

Claimant is only 23 years of age. She nearly completed the 11th grade and has fulfilled 80 hours of college course work. She is certified as both a nurse's assistant and nurse's aide. She has work experience in both of the aforementioned fields. At the time of the hearing, she was employed as a certified nurse's assistant.

Following our de novo review, we conclude that claimant's low back impairment is in the minimal range. Exercising our independent judgment in light of claimant's level of impairment and the relevant social and vocational factors, we conclude that an award of five percent unscheduled permanent disability appropriately compensates claimant for her permanent loss of earning capacity due to the compensable 1984 injury. We, therefore, affirm the Referee's award.

Lastly, we consider the Referee's award of a $400 attorney's fee for claimant's attorney's services in overturning the insurer's partial denial with respect to claimant's sacroiliac condition. We modify.

In determining a proper attorney fee, we look to the efforts of the attorney and the results obtained. OAR 438-47-010(2); see also Arthur D. Roppe, 38 Van Natta 118 (1986). Exercising our independent judgment, we find an attorney fee of $800 to be appropriate in this case.

ORDER

The Referee's order dated November 6, 1986 is modified in part and affirmed in part. That portion of the Referee's order that awarded a $400 attorney fee is modified. The insurer shall pay claimant's attorney a fee of $800 in addition to, not out of, any compensation due claimant. The remainder of the Referee's order is affirmed.

CHARLES T. BRENCE, Claimant
Michael B. Dye, Claimant's Attorney
Cowling & Heysell, Defense Attorneys
Art Stevens (SAIF), Defense Attorney

WCB 85-14936, 85-15871 & 85-16044
July 31, 1987
Order of Remand

Reviewed by Board Members Lewis and Ferris.

Claimant requested Board review of Referee Howell's order dated August 19, 1986. The primary issue before the Referee was responsibility between insurers for claimant's low back condition. In addition, however, claimant represented that during the closing arguments that followed the hearing, the parties verbally stipulated that his attorney fees, if any, would be paid in addition to, rather than out of, his compensation. Although claimant requested that closing arguments be recorded, no party asked that they be transcribed. As a part of his request for Board review, claimant asked that we order and bear the cost of a transcription of those arguments.

In an interim order dated May 28, 1987, we denied claimant's request. We further provided, however, that if claimant wished to obtain a transcription of closing arguments at his own expense, we would remand this case to the Referee for

consideration of the transcript and a determination of attorney fees. We asked claimant to notify us of his intent with regard to payment for the transcription.

Claimant has responded. He has agreed to bear the cost of the transcription and asks that the case now be remanded to the Referee.

ORDER

This case is remanded to the Referee for further proceedings consistent with this order. Claimant shall obtain a transcription of the closing arguments of the July 29, 1986 hearing. Thereafter, the Referee shall review the transcript and shall prepare an order regarding the attorney fees, if any, to which claimant is entitled.

DONALD W. COURTIER, Claimant
Carney, et al., Claimant's Attorneys
Moscato & Byerly, Defense Attorneys
SAIF Corp Legal, Defense Attorney

WCB 86-12368
July 31, 1987
Order on Review

Reviewed by Board Members Ferris and Lewis.

Claimant requests review of Referee Knapp's Order on Reconsideration that: (1) found that claimant was not entitled to temporary partial disability or temporary total disability following his termination from his employment; (2) declined to assess a related penalty and attorney fee; (3) declined to award any unscheduled permanent disability for his back condition; and (4) determined that the insurer's delay in submitting the claim for closure did not warrant a penalty and attorney fee. The issues are temporary disability, extent of unscheduled permanent disability, and penalties and attorney fees.

The Board affirms the Referee's Order on Reconsideration with the following comment.

In April 1981, claimant sustained a compensable injury to his low back. Dr. Rinehart diagnosed recurrent lumbar pain and released claimant from work. After a period of conservative treatment and physical therapy, Dr. Rinehart released claimant to modified work in July 1981. Subsequently, claimant was involved in a car accident that resulted in his inability to work from November 17, 1981 to December 3, 1981. In January 1982, claimant received a Determination Order awarding no permanent disability. During 1982, claimant continued periodic treatments with Dr. Rinehart.

In October 1982, Dr. Puziss examined claimant and noted that he had increased complaints of pain with sitting and standing. However, Dr. Puziss found no evidence of permanent impairment. On January 20, 1983, Dr. Rinehart reported that claimant needed physical therapy and that his work severely aggravated his back condition. By January 27, 1983, Dr. Rinehart stated that claimant had marked tenderness and would probably experience permanent disability. Claimant filed an aggravation claim with the insurer and a new injury claim directly with his employer, who had become self-insured. Both the employer and insurer denied the claim on the basis of responsibility and compensability.

On January 31, 1983, claimant telephoned his employer to report he was ill and would not be available for work. Claimant remained absent from work for the following week. However, he did not call daily to report his absence from work pursuant to company policy. On February 9, 1983 claimant received a certified letter advising that further failure to promptly report an illness would result in termination. Claimant could have filed a grievance through his union concerning the letter, but chose not to. On February 8, 1983 claimant obtained Dr. Rinehart's release from work. Dr. Rinehart released claimant to modified work on March 21, 1983. Claimant returned to modified work at his regular wage with the employer on March 29, 1983.

On April 18, 1983, claimant testified that he awoke with severe pain in his back. He took sleeping medication to help him return to sleep. As a result, he did not awaken for work and failed to call his supervisor to report his absence. Although claimant testified he was awake by 1 p.m., he still failed to call and explain the reason for his absence. At 3 p.m. his supervisor telephoned to ascertain why he had failed to report for work. Claimant's explanation was determined to be inadequate and his employment was terminated.

Subsequently, claimant applied for unemployment benefits, which was denied. Claimant appealed the denial and an unemployment hearing was held on June 6, 1983. Claimant was represented by a law clerk from the Multnomah County Legal Aid Service. Witnesses were called and evidence presented. Following the hearing, the Referee concluded claimant was not entitled to unemployment compensation as he had been terminated for misconduct. This decision was affirmed by the Employment Appeals Board.

In December 1985 the Workers' Compensation Board reversed a Referee's Opinion and Order and found that claimant had sustained an aggravation of his low back condition in January 1983. Donald W. Courtier, 37 Van Natta 1689 (1985). The claim was remanded to the insurer for processing. In response, the insurer paid temporary total disability from January 20, 1983 until claimant returned to modified work on March 29, 1983. No temporary disability was paid following March 29, 1983. On March 28, 1986, the Orthopaedic Consultants examined claimant and found him medically stationary without impairment. On March 17, 1986 claimant was examined by Dr. Puziss, who had previously examined claimant in October 1982, March 1983 and September 1983. Dr. Puziss opined that claimant had sustained an aggravation in January 1983, but that he was medically stationary by the time of his September 9, 1983 examination. On May 5, 1986, a Determination Order issued that awarded temporary partial disability from January 17, 1983 through September 9, 1983. Claimant received no permanent disability award.

Claimant asserts that he is entitled to temporary partial disability following his April 18, 1983 termination. We disagree.

When claimant returned to modified work on March 29, 1983 he was receiving his regular wage. Consequently, claimant's rate of temporary partial disability was zero. At the time of claimant's injury, OAR 436-54-222(6)(b) provided that temporary partial disability compensation shall continue to be paid until:

> "The duration of the offered job has expired or that the offer of such employment is withdrawn. (The employer discharging the worker because of violation of normal employment standards shall not be considered a withdrawal of offered employment.)"

The Referee concluded that claimant's failure to call in to report his illness after receiving the warning letter was a violation of normal employment standards. See Rayle R. Jansen, 38 Van Natta 1027 (1986); Gloria J. Bas, 36 Van Natta 175 (1984); Thomas Harrell, 34 Van Natta 589 (1982). In making this decision, the Referee relied on the findings of the employment hearing's Referee. With regard to the employment hearing, the Referee stated "Collateral estoppel should apply because the issue is identical and was determined on the merits of the first proceeding."

Despite the application of collateral estoppel, the Referee did take additional evidence on claimant's employment termination. On the merits, we agree that claimant did violate "normal employment standards." However, we conclude that, in this forum, collateral estoppel does not apply to findings of fact from the Employment Division. In Gloria J. Bas, 36 Van Natta 175, 179 (1984), we stated "that a claimant's entitlement to workers' compensation benefits will be determined on this agency's judgment concerning the relative reasonableness of claimant's actions." (emphasis added). Further, the fact finding process of the two forums is substantially different. The Employment Division applies its own legal and evidentiary standards and allows for nonlegal representation at hearing. As a result of these differences, this forum should not be bound by the Employment Division's findings of fact. Although not binding, the Unemployment Division's findings are probative and were properly admitted into evidence.

Claimant next asserts that he is entitled to temporary disability following his termination. Claimant contends that the insurer failed to comply with the requirements of notice to the worker and Compliance Division. Specifically, claimant relies on OAR 436-54-222(7), which at the time of claimant's injury stated:

> "The insurer or self-insured employer shall provide a written explanation to the injured worker of the reasons for changes in the compensation rate and the method of computation whenever temporary total disability compensation is terminated and temporary partial disability compensation commences, and vice versa. A copy of the letter to the worker shall be sent to the Compliance Division in cases where a worker has refused wage earning employment."

Claimant argues that the rule should also apply in situations where claimant has been terminated for violation of normal employment standards. We disagree.

Claimant returned to modified work on March 29, 1983. At that time, his entitlement to temporary total disability ceased

and the insurer was only obligated for payment of temporary partial disability. Because claimant returned to modified work for the same wage, his rate of temporary partial disability was zero. Following claimant's termination for violation of normal employment standards, he was entitled only to continued payment of temporary partial disability. Thomas Harrell, supra. Therefore, by not paying claimant, the insurer satisfied its obligation to pay temporary partial disability until the claim was closed by the May 5, 1986 Determination Order. Since there was no change in the rate following his termination, claimant was not entitled to notice pursuant to OAR 436-54-222(7).

ORDER

The Referee's Order on Reconsideration dated November 6, 1986 is affirmed.

TONY FAZZOLARI, Claimant
Robert L. Burns, Claimant's Attorney
Beers, et al., Defense Attorneys

WCB 85-16090
July 31, 1987
Order on Review

Reviewed by Board Members Ferris and Lewis.

Claimant requests review of that portion of Referee Shebley's order that granted the insurer an offset for overpaid temporary disability compensation. The insurer cross-requests review, seeking clarification of the precise offset period. We modify.

Dr. Button, claimant's treating physician, released him to return to regular work on March 22, 1985. Button did not, however, consider claimant medically stationary until August 1985. The insurer continued to pay temporary disability benefits through September 2, 1985. A Determination Order issued in October 1985, awarding claimant temporary disability benefits through March 22, 1985.

Claimant appealed the Determination Order, requesting a hearing on the issue of extent of his permanent disability. The insurer cross-appealed, contending entitlement to an offset of temporary disability benefits in the amount of $7,612.52. At the hearing, the insurer requested permission to offset all temporary disability benefits paid beyond March 22, 1985.

Citing ORS 656.268(2), the Referee determined that the insurer was entitled to "a credit or offset for all temporary [disability] benefits paid beyond March 22, 1985." (Emphasis added). However, in the "order" portion of his order, the Referee stated:

> "[The insurer's] request for a credit in the sum of $7617.40 for temporary disability compensation paid claimant beyond the date he became medically stationary is granted." (Emphasis added).

Interpreting the Referee's order, we find that he inadvertently ordered the offset only beyond the date claimant became medically stationary (August 1985) rather than the date claimant was released to return to regular work (March 22, 1985). Our reasoning is twofold: First, the Referee stated in the body

of his order that the insurer was granted an offset for the period "beyond March 22, 1985." Secondly, the "$7,617.40" offset ordered by the Referee applies to the period beyond March 22, 1985, not August 1985.

ORDER

The Referee's order is modified in part and affirmed in part. In lieu of that portion of the Referee's order that granted the insurer an offset for temporary disability benefits paid back to the date claimant became medically stationary, the insurer is allowed an offset of the amounts paid after the date claimant was released to return to regular work; i.e., March 22, 1985. The remainder of the Referee's order is affirmed.

DERAL E. MANLEY, Claimant
Steven C. Yates, Claimant's Attorney
SAIF Corp Legal, Defense Attorney

WCB 86-08478
July 31, 1987
Order on Review

Reviewed by Board Members Ferris and Lewis.

Claimant requests review of Referee Daughtry's order that found that the SAIF Corporation had not failed to pay medical bills pursuant to an April 4, 1986 Stipulation and Order. Claimant alleges he was not allowed an evidentiary hearing. He, therefore, seeks remand.

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

Claimant filed a request for hearing and application to schedule seeking penalties and attorney fees for SAIF's failure to pay medical bills as specified by a Stipulation and Order. The Referee issued a Show Cause Order requesting SAIF to respond to the allegation. In response to the order, SAIF sent a letter and claim information and asserted that it had fully complied with the Stipulation and Order. Subsequently, the Referee sent a letter to claimant's attorney requesting information surrounding the unpaid medical bills. The letter informed claimant's attorney that "[u]pon receipt of the above, this matter will be decided by [sic] final, appealable order."

After receipt and consideration of the requested information, the Referee issued his Opinion and Order, concluding that SAIF had complied with the Stipulation and Order. On appeal, claimant asserts that he was not given an opportunity for a hearing, and he seeks remand. We find that remand is not warranted.

The Referee's request for documentary evidence from claimant stated that upon receipt of the information a final and appealable order would be issued. Claimant sent the material and made no objection to proceeding on this basis. In so doing, claimant implicitly agreed to have the matter decided on the record without a hearing. Consequently, the record has not been incompletely or insufficiently developed and remand is not warranted. ORS 656.295(5).

ORDER

The Referee's order dated October 16, 1986 is affirmed.

EVELYN L. BENTON, Claimant
Dennis O'Malley, Claimant's Attorney
Chelsea Mohnike (SAIF), Defense Attorney
Moscato & Byerly, Defense Attorneys

WCB 86-05771 & 86-06755
August 4, 1987
Order of Dismissal

The SAIF Corporation has moved the Board for an order dismissing a request for Board review filed by ARA Transportation. SAIF asserts that it did not timely receive notice of the request for review. SAIF's motion is granted.

The Referee's Opinion and Order was mailed on April 30, 1987. In a letter dated May 28, 1987, ARA Transportation requested Board review. The request for review included a certificate of personal service by mail to claimant's attorney. However, neither an acknowledgment of service upon SAIF or its insured nor a certificate of mailing to SAIF or its insured was provided with the letter. The Board acknowledged the request for review on June 3, 1987 by way of its computer-generated acknowledgement letter. SAIF did not receive a copy of ARA Transportation's request until June 6, 1987, or more than 30 days after the Referee's order was mailed.

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 must be mailed to the Board and copies of the request must be mailed to all parties to the proceeding before the Referee. ORS 656.295(2).

In Argonaut Insurance Co. v. King, 63 Or App 847, 852 (1983), the court held that "compliance with ORS 656.295 requires that statutory notice of the request for review be mailed or actual notice be received within the statutory period." In King, the request for review was timely, but copies of the request were never sent to the other parties. The "actual notice" referred to by the court was the Board's computer generated acknowledgement letter, which the evidence established was received by the insurer more than 30 days after the Referee's order was mailed. The court found that because the insurer's notice of the request for review was untimely, the Board lacked jurisdiction to consider the appeal.

Here the record is that neither SAIF nor its insured received a copy of the request for Board review within the 30-day statutory period. Moreover, there is no evidence that either party received actual knowledge of the request within that period. Consequently, we lack jurisdiction to review the Referee's Order of Dismissal, which has become final by operation of law. See ORS 656.289(3), Argonaut Insurance Co. v. King, supra.

ARA Transportation's request for Board review is dismissed.

IT IS SO ORDERED.

THEODORE W. LINCICUM, Claimant
Pozzi, et al., Claimant's Attorneys
Davis, et al., Defense Attorneys

WCB 86-09100
August 4, 1987
Order Denying Motion to Allow Oral Argument

Aetna Casualty Company has requested that this case be set for oral argument before the Board. The insurer asserts that the case involves "questions of propriety of procedures which could have broad implications and impact upon litigants not involved in this case."

Aetna's request is denied. See Frank Roberts, 37 Van Natta 730 (1985).

IT IS SO ORDERED.

STEPHEN E. McKINNEY, Claimant
Callahan, et al., Claimant's Attorneys
Acker, et al., Defense Attorneys

WCB 86-04354
August 4, 1987
Order on Review

Reviewed by Board Members McMurdo and Ferris.

The insurer requests review of Referee Seymour's order that: (1) disapproved its unilateral termination of claimant's temporary total disability compensation once he was incarcerated; and (2) assessed a 25 percent penalty and accompanying attorney fee for what the Referee found to be an unreasonable termination of benefits. The issues are whether claimant's benefits should have been unilaterally terminated and, if not, whether the termination was unreasonable.

Although we make no finding with regard to whether or not an incarcerated claimant is entitled to temporary total disability compensation, we agree with the Referee that claimant's benefits should not have been unilaterally terminated. See Lloyd Fisher, 39 Van Natta 5 (1987); Jackson v. SAIF, 7 Or App 109 (1971). We disagree, however, that the insurer's termination of benefits was unreasonable. We, therefore, set aside the Referee's assessment of penalties and attorney fees.

For penalties and attorney fees to be appropriate, there must be a finding that the insurer's conduct was unreasonable. Mt. Mazama Plywood v. Beattie, 62 Or App 355 (1983). If the insurer has a legitimate doubt as to its liability, penalties are generally not appropriate. Kosanke v. SAIF, 41 Or App 17 (1979).

In effecting its termination of claimant's benefits, the present insurer was apparently guided by an Attorney General's opinion that an incarcerated claimant is not entitled to temporary disability compensation. Because the insurer is a private business entity, it is not entitled to rely on the advice given by the Attorney General. See 180.060(3). However, we find that the opinion was sufficient to raise legitimate doubt as to the insurer's continuing liability once claimant became incarcerated. Penalties and attorney fees were, therefore, not appropriate.

ORDER

The Referee's order dated November 6, 1986 is reversed in part and affirmed in part. That portion of the order that assessed a penalty and associated attorney fee for the insurer's unilateral termination of claimant's temporary total disability compensation is reversed. The remainder of the order is affirmed. Claimant's attorney is awarded $400 for services on Board review, to be paid by the insurer.

ROBERT F. SCHARDT, Claimant
Pozzi, et al., Claimant's Attorneys
Schwabe, et al., Defense Attorneys

WCB 85-04324
August 4, 1987
Order Denying Motion to Dismiss

Claimant has moved the Board for an order dismissing the insurer's request for review on the ground that the request was untimely filed. The motion is denied.

On May 22, 1987, the Referee issued an Interim Order. This order did not contain a statement explaining the parties' rights of appeal under ORS 656.289 and 656.295. Pursuant to the order, the insurer's denial of claimant's injury claim was set aside and the claim was remanded to the insurer for processing according to law. The order specifically directed claimant's counsel to submit, within ten days, an affidavit detailing his services. The insurer's counsel was allowed ten days to respond to the affidavit. Following receipt of these documents, the order advised that an appropriate attorney fee award would be determined.

On June 2, 1987, claimant's attorney submitted an affidavit outlining his services. On June 4, 1987, the insurer raised objections to the submission, to which a response was made on June 5, 1987. On June 8, 1987, the insurer replied to the response.

On June 9, 1987, the Referee issued an Opinion and Order. This order contained a statement explaining the parties' rights of appeal under ORS 656.289 and 656.295. In addition, the order specifically incorporated by reference the May 22, 1987 Interim Order. The order also awarded claimant an extraordinary attorney fee. On June 23, 1987, the insurer requested Board review of the Referee's June 9, 1987 order and the May 22, 1987 Interim Order.

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 order shall contain a statement explaining the rights of the parties under ORS 656.289 and 656.295. id.

In support of the motion to dismiss, claimant cites Farmers Insurance Group v. SAIF, 301 Or 612 (1986). In Farmers, a Referee issued an order finding SAIF responsible for an asbestosis claim. The order contained a statement concerning the parties' rights of appeal under ORS 656.289 and 656.295. No provision for an attorney fee was present in the order. Instead, accompanying the order was the Referee's letter advising the parties to expect a "supplemental attorney fee Order." The Referee requested that the parties refrain from appealing the current order, until the issuance of the "Supplemental Order." Thereafter, the Supplemental Order issued, solely concerning the issue of attorney fees. It did not purport to republish, incorporate or reconsider the Referee's prior order. SAIF requested Board review more than 30 days from the issuance of the Referee's initial order, but less than 30 days from the issuance of the supplemental order. Reasoning that the initial order met the ORS 656.289(1) and (3) requirements for an order, the Supreme Court concluded that the order became final 30 days from its mailing. Consequently, the Court held that the Board had lacked jurisdiction to consider SAIF's appeal insofar as it related to the responsibility finding made in the Referee's initial order.

The present case is distinguishable. Here, as in Farmers, the Referee's initial order pertained to a fundamental issue directly affecting claimant's right to compensation. However, contrary to the facts present in Farmers, the Referee's May 22, 1987 order was expressly labeled "Interim Order." As such, again unlike the facts of Farmers, this order did not contain a statement explaining the parties' statutory rights of appeal. Furthermore, the order itself directed the parties to submit additional information concerning the attorney fee issue. It was only after the parties' compliance with the Interim Order that the Referee issued an Opinion and Order. Contrary to the situation present in Farmers, this was the first order that contained a statement explaining the parties' rights of appeal under ORS 656.289 and 656.295. Moreover, unlike the subsequent order in Farmers, this order specifically incorporated by reference the Referee's prior order.

Under these circumstances, we find that the May 22, 1987 Interim Order did not meet the ORS 656.289(1) and (3) requirements for an order. Consequently, we conclude that it was not appealable. Furthermore, even if the May 22, 1987 order was an appealable order, it was expressly incorporated within the June 9, 1987 Opinion and Order. Therefore, because the insurer timely requested Board review of the June 9, 1987 order, we have jurisdiction to consider this matter.

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

IT IS SO ORDERED.

BARBARA A. SOMMERS, Claimant
Malagon & Moore, Claimant's Attorneys
Acker, et al., Defense Attorneys

WCB 85-13813
August 4, 1987
Order on Review (Remanding)

Reviewed by Board Members McMurdo and Lewis.

The insurer requests review of those portions of Referee Foster's order that: (1) set aside its denial of claimant's aggravation claim relating to left thoracic outlet syndrome; (2) set aside its denial of claimant's claim for medical services relating to left thoracic outlet syndrome; (3) required it to pay interim compensation from September 12, 1985 through July 24, 1986; and (4) assessed penalties and attorney fees for failing to timely accept or deny claimant's aggravation and medical services claims. The insurer also requests that the Board remand the case to the Referee for further development on the aggravation issue and other related issues. The issues are remand, aggravation, interim compensation, medical services, penalties and attorney fees.

At the time of the hearing, the parties and the Referee were proceeding under the mistaken assumption that claimant's aggravation rights had expired and that the only issues were medical services and related penalties and attorney fees. After the hearing, claimant's attorney discovered the error and wrote the Referee, asking that he consider the issues of aggravation and related penalties and attorney fees in addition to the issues raised at the hearing. In a letter dated October 7, 1986, the Referee stated that he would proceed to issue his Opinion and

Order, but did not clearly indicate that he would consider the issues raised by claimant after the hearing. The Referee, in fact, did decide the issues of aggravation and related penalties and attorney fees in his Opinion and Order.

The insurer contends on Board review that the Referee did not allow it an opportunity to develop the record on the aggravation and related issues and asks that the case be remanded. We agree and grant the insurer's request.

ORDER

The Referee's order dated November 13, 1986 is vacated and the case is remanded to the Referee for further proceedings consistent with this order.

LAVON C. CHRISTENSEN, Claimant
McKeown & O'Dell, Claimant's Attorneys
Moscato & Byerly, Defense Attorneys

WCB 85-12028
August 6, 1987
Order on Review

Reviewed by Board Members McMurdo and Ferris.

The insurer requests review of that portion of Referee Quillinan's order that set aside its denial of claimant's occupational disease claim for bilateral foot and lower leg pain. The issue on review is compensability.

Claimant, 50 years of age at the hearing, began working for the employer in 1982, as a nurse and phlebotomist. Her duties required that she stand or walk for seven and one-half hours each day. Previous employment included work as a truck driver, a private nurse, a medical assistant, a nurse's aide, and a teacher's aide. She had no problems with her feet in any of these employments.

Soon after beginning employment, claimant's feet began to ache. She was examined by Dr. Brown, a general practitioner, who diagnosed leg fatigue secondary to standing. Claimant continued working without difficulty until April 1985, at which time she experienced pain in her feet radiating into her legs. She testified that this problem was different than her earlier problem in 1982, characterizing the latter as "pain" and the former as merely an "ache."

Claimant was examined by Dr. Roy, a sports physician, in June 1985. Dr. Roy diagnosed excessive pronation and prescribed orthotics. A few months later, Dr. Roy restricted claimant to a desk job. However, the employer was unable to accommodate claimant; thus, she quit her job. In August 1985, she filed an occupational disease claim for bilateral foot and lower leg pain. The insurer timely denied the claim. Claimant began work as a receptionist in October 1985, which did not require prolonged standing or walking.

In November 1985, Dr. Brown reported that he did not feel qualified to render an opinion regarding the cause of claimant's alleged occupational disease. That same month, Dr. Roy opined that claimant's employment was the major contributing cause of her "problem." Dr. Roy further stated that claimant's tendinitis was "related to pronation and excessive standing, resulting in overuse of the foot." Dr. Roy's report fails to mention any non-work activities.

Dr. Vetter, a podiatrist, performed an independent medical examination in December 1985. Dr. Vetter reported that it was a mere coincidence that claimant's pronated foot structures became symptomatic while working for the employer. Although Dr. Vetter was unaware of "any extra curricular activities such as hiking, jogging or aerobics," he felt that claimant's symptoms could be related to non-work activities. Subsequently, Dr. Vetter testified by deposition that claimant's tendinitis was only a symptom of her preexisting pronation condition, rather than a worsening of such condition.

Claimant testified that she exercised regularly, including bicycling, jogging, and walking.

The Referee found that claimant's tendinitis was compensable as either a separate condition or as a worsening of her preexisting pronation condition. We do not agree for the following reasons.

The medical evidence does not preponderate in favor of a finding that claimant's tendinitis is a separate condition. Dr. Vetter opined that claimant's tendinitis was a symptom of her preexisting pronation condition. Likewise, Dr. Roy reported that claimant's tendinitis was related, in part, "to pronation." Thus, we conclude that claimant's tendinitis is not an independent condition severable from her preexisting pronation condition.

Consequently, to establish the compensability of her occupational disease claim, claimant must prove that work conditions caused a worsening of her preexisting pronation condition producing disability or the need for medical services. Weller v. Union Carbide Corp., 288 Or 27, 35-36 (1979); see also Wheeler v. Boise Cascade, 298 Or 452 (1985). In addition, she must establish that her work conditions were the major contributing cause of the worsening of her preexisting condition. Dethlefs v. Hyster Co., 295 Or 298 (1983).

Dr. Vetter opined that claimant's preexisting pronation condition had not worsened. According to Vetter, claimant had suffered from the onset of symptoms only. Thus, claimant must rely on Dr. Roy to prove a worsening of her preexisting condition. Dr. Roy stated as follows:

> "In my opinion, [claimant's] foot pain was a result of her working activity, which I am told consisted of her being on her feet on cement for most of the day. When she was off her feet, her symptoms improved. Therefore, it appears to me that her injury was work-related, and that the work was the major contributing cause of her problem."

Dr. Roy refers to "foot pain," to "symptoms," to an "injury," and to a "problem." He does little to resolve whether claimant has sustained a worsening of her preexisting condition or merely a worsening of symptoms. Under these circumstances, we conclude that claimant has not established by a preponderance of the evidence that her preexisting pronation condition has worsened. See Hutcheson v. Weyerhaeuser Co., 288 Or 51, 56 (1979). Therefore, her claim is not compensable.

Having found no worsening of claimant's preexisting pronation condition, we need not consider whether her employment was the major contributing cause thereof. However, had we found to the contrary, we would conclude that her employment was not the major contributing cause of any worsened condition.

Claimant testified that she bicycled, jogged, and walked on a daily basis. The Referee concluded that neither Drs. Roy nor Vetter knew about claimant's off job activities. We agree.

An examination of Dr. Roy's November 1985 report, shows that his opinion is based on what he was "told." Dr. Roy makes no mention of claimant's non-work activities. This failure to weigh the effect of such activities detracts from the persuasiveness of his opinion. See Joan M. Sanders, 38 Van Natta 539, 543 (1986). Furthermore, Dr. Vetter reported that claimant did not inform him of her non-work activities such as hiking or jogging. Such information would only support Dr. Vetter's opinion that claimant's condition is not work related.

ORDER

The Referee's order dated May 16, 1986, is reversed. The insurer's denial of claimant's claim for bilateral foot and lower leg pain is reinstated.

RONALD L. HEISINGER, Claimant
Vick & Gutzler, Claimant's Attorneys
Davis, Bostwick, et al., Defense Attorneys

WCB 85-08605
August 10, 1987
Order on Reconsideration

Claimant has requested reconsideration of our Order on Review dated July 21, 1987. In that order, we supplemented the Referee's order by setting aside the insurer's denial of claimant's claim for palliative medical services. In doing so, we awarded claimant an attorney fee for services on Board review, but inadvertently failed to award attorney fees for services at hearing.

Claimant's request for reconsideration is granted and we withdraw our prior order. On reconsideration, we supplement our prior order to award claimant an attorney fee of $700 for services at hearing in setting aside the insurer's denial of medical services. Except as herein supplemented, we adhere to and republish our prior order, effective this date.

IT IS SO ORDERED.

PAUL D. FIX, Claimant
Van Natta & Peterson, Claimant's Attorneys
SAIF Corp Legal, Defense Attorney

Own Motion 86-0617M
August 12, 1987
Own Motion Determination on Reconsideration

The Board issued an Own Motion Determination on June 4, 1987 whereby claimant's claim was closed. Claimant has requested that the Board increase his permanent partial disability award. SAIF Corporation opposes the increase, stating claimant has no right to appeal the Board's prior order.

SAIF misunderstands both the law and meaning of the language in the Board's order. ORS 656.278(3) provides in part that a "...claimant has no right to appeal any order or award made

by the board on its own motion, except when the order diminishes or terminates a former award." This language is paraphrased in all of the Board's own motion orders. Both the statute and the language in our orders mean that a claimant has no right to appeal an adverse own motion order to the Court of Appeals. Neither the statute nor our orders prohibit a claimant or an insurer from requesting reconsideration of a prior own motion order.

It is the Board's policy to entertain all requests for reconsideration of its own motion orders, whether filed by the claimant or the insurer. We consider the Claimant's letter of July 6, 1987 to be a request to reconsider of our June 4, 1987 Own Motion Determination. On reconsideration, the Board finds that claimant is entitled to an increased award equal to 16 degrees for 5 percent unscheduled disability. This award is in addition to any prior awards claimant has been granted for this injury.

IT IS SO ORDERED.

ARVIN R. MARTIN, Claimant
Merrill Schneider, Claimant's Attorney
Jeff Gerner (SAIF), Defense Attorney

WCB 86-12727
August 12, 1987
Order on Review

Reviewed by Board Members Lewis and Ferris.

Claimant requests review of those portions of Referee Howell's order that: (1) upheld the SAIF Corporation's denial of his aggravation claim for a low back condition; (2) awarded interim compensation from April 18, 1986, rather than April 8, 1986; (3) awarded an attorney fee out of, not in addition to, the increased compensation; and (4) awarded a 20 percent penalty for SAIF's failure to pay interim compensation. The issues are aggravation, interim compensation, and penalties and attorney fees.

We modify the Referee's award of interim compensation. All remaining issues are affirmed.

ORS 656.262(10) provides that interim compensation shall begin within 14 days after the employer has notice or knowledge of the claim. At the hearing, the parties stipulated that SAIF received claimant's aggravation claim on April 8, 1986. Further, SAIF concedes "that interim compensation should have begun on April 8, 1986."

Accordingly, we find that claimant is entitled to interim compensation beginning April 8, 1986. The penalty for failing to pay interim compensation shall also be modified accordingly.

ORDER

The Referee's order is modified in part, and affirmed in part. That portion of the Referee's order that awarded claimant interim compensation from April 18, 1986 is modified. Claimant is awarded interim compensation from April 8, 1986 through June 3, 1986. The penalty for failing to pay interim compensation shall also be modified accordingly. The remaining portions of the Referee's order are affirmed. Claimant's attorney is awarded a

reasonable attorney fee equal to 25 percent of the increased compensation granted by this order. However, the total of fees allowed by the Referee and the Board concerning the interim compensation issue shall not exceed $3,000.

WILLIAM P. ADAMS, Claimant
Peter O. Hansen, Claimant's Attorney
Nelson, et al., Defense Attorneys
David O. Horne, Defense Attorney

WCB 86-05722, 85-07875 & 86-02125
August 14, 1987
Order on Review

Reviewed by Board Members Ferris and McMurdo.

Liberty Northwest Insurance Corporation (Liberty) requests review of that portion of Referee Pferdner's order that: (1) set aside its denial of claimant's new injury claim for the neck and shoulders; and (2) upheld Wausau Insurance Company's (Wausau) "de facto" denial of claimant's aggravation claim in that regard. The issues are compensability and responsibility. We reverse.

Claimant incurred four compensable injuries while employed by Wausau's insured. The first was to the low back in 1976. The second was a neck and thoracic injury that occurred in 1980. The third also involved the cervical/thoracic spine, and it resulted from claimant's being struck by a log in February 1981. The fourth was a low back strain resulting from a January 1982 slip and fall incident. The record is that claimant suffered ongoing intermittent symptoms in the neck and upper back following the 1980 injury. A July 15, 1982 Determination Order awarded temporary total disability only with regard to the last injury insured by Wausau.

Claimant submitted a claim for an aggravation of his February 1981 injury in mid-1982. Wausau issued a denial of that claim in October 1982, asserting that claimant's condition had not worsened since the last arrangement of compensation. There is no evidence that Wausau's denial was appealed. Claimant did request a hearing with regard to the Determination Order award, however, seeking additional temporary and permanent disability compensation. On June 3, 1983, Referee Richard Knapp affirmed the Determination Order in its entirety. In doing so, he clarified that the only viable issue before him involved the January 1982 claim, for claimant had failed to request a hearing on the denial of his aggravation claim involving the 1981 injury. Claimant did not request Board review of the Referee's order.

On February 24, 1986, claimant suffered another injury, this time while employed by Liberty's insured. He reported a return of severe neck and upper back symptoms after lifting heavy sacks of grain. He sought additional treatment and was again diagnosed as having suffered an acute cervical/thoracic strain. Dr. Tesar, claimant's initial treating physician, reported that the most recent injury should be considered an aggravation of the January 1982 injury. Claimant subsequently filed claims with both Liberty and Wausau. While Liberty's denial dealt only with the issue of responsibility, Wausau apparently informed the Workers' Compensation Department that it was denying compensability as well. Based on that representation, the Department refused to appoint a paying agent pursuant to ORS 656.307.

In April 1986, claimant returned to Dr. Grimm, who had

treated him following the 1982 injury. Grimm opined that claimant's condition had not worsened since May 1983, or before Referee Knapp's Opinion and Order. He also felt that while the latest injury contributed to claimant's need for medical attention, it was essentially an aggravation of the 1981 injury.

The Referee upheld Wausau's "de facto" denial of claimant's aggravation claim following the 1986 injury, finding that the report on which claimant relied as a claim for aggravation was insufficient for that purpose. He set aside Liberty's denial of claimant's new injury claim, however, finding that the February 1986 injury "aggravated or exacerbated" claimant's condition so as to make Liberty responsible therefor.

This is a successive injury case in which claimant has accepted claims for the neck and upper back dating to 1980 and 1981, as well as an accepted claim for the low back dating to 1982. The most recent claim relates to the neck and upper back. It has been accepted by neither insurer. The issue is which, if either, of the insurers is now responsible for claimant's condition.

In Hensel Phelps Construction Co. v. Mirich, 81 Or App 290 (1986), the court held that in a successive injury case, a worsening of symptoms alone is insufficient to place responsibility on the later employer. Rather, the second injury must independently contribute to the causation of the disabling condition, i.e., to a worsening of the underlying condition. Id. at 284. In the present case, the persuasive medical evidence is that claimant's condition has not worsened since 1983. Further, there is no persuasive medical evidence that the 1986 injury independently contributed to a worsening of claimant's condition. Liberty's denial of claimant's claim for a new injury in 1986 should have been affirmed.

We are left to determine whether claimant has a compensable claim for aggravation. We find that he does not. As noted, supra, and as previously found by Referee Knapp, an aggravation claim with regard to the 1981 injury is no longer viable. With regard to the 1982 injury, the persuasive medical evidence is that claimant's condition has not worsened since May 1983, which was before Referee Knapp's Opinion and Order. In any event, claimant has not requested review of the present Referee's finding that he failed to prove a compensable aggravation of the 1982 injury. Rather, claimant merely asks that the Referee's finding regarding Liberty's responsibility for a new injury be affirmed.

We find that claimant has not suffered a "new injury," as that phrase is used in a responsibility context. We further find that claimant has not suffered a compensable worsening of his condition since the last arrangement of compensation. The Referee's order shall, therefore, be reversed in part and affirmed in part.

ORDER

The Referee's order dated September 30, 1987 is reversed in part and affirmed in part. That portion of the order that set aside Liberty Northwest Insurance Corporation's denial of claimant's new injury claim is reversed and the denial is reinstated. The remainder of the Referee's order is affirmed.

RICHARD A. BENTON, Claimant
Charles D. Maier, Claimant's Attorney
Cummins, et al., Defense Attorneys

WCB 86-01094
August 14, 1987
Order on Review

Reviewed by Board Members McMurdo and Lewis.

The insurer requests review of those portions of Referee Wilson's order that: (1) set aside its denial of claimant's aggravation claim for a low back condition; (2) set aside its denial of a claim for thermography; and (3) assessed a 25 percent penalty and a $500 attorney fee for an alleged untimely payment of "interim" compensation. The insurer argues that the penalty and fee were excessive. Although claimant has not formally cross-requested review, his brief asks that we reverse the Referee's finding that claimant's thoracic and cervical conditions are not compensable. The issues are aggravation, thermography, whether the penalties and attorney fees awarded by the Referee were excessive, and the compensability of claimant's thoracic and cervical conditions.

We affirm the Referee's order, except that portion that found claimant's low back aggravation claim to be compensable.

Claimant compensably injured his low back in late October 1984. The insurer accepted the claim and closed it on February 25, 1985, awarding only a brief period of temporary total disability compensation. Claimant continued to work full-time for his employer until he was terminated for reasons unrelated to his compensable injury. Approximately two months later, claimant began working for a second employer.

On December 12, 1985, Dr. Utter, a chiropractor, notified the insurer that claimant had reported an October 25, 1985 injury to the low back, right upper back and neck, resulting primarily in a constant ache in the low back. Claimant related that he had left work in early October due to pain, and Utter authorized time off work beginning October 7, 1985. Utter treated claimant through February 1986 for what he interpreted to be a compensable worsening of claimant's original compensable condition.

Claimant was examined by a panel of Western Medical Consultants physicians in January 1986. Based on claimant's history, the panel related his low back complaints to the compensable injury. Claimant was also seen by Dr. Buza, a neurosurgeon. Buza found claimant to have suffered a low back musculoligamentous strain, although he did not offer an opinion regarding causation.

Claimant testified that following the 1984 compensable injury, he went to an emergency room, received treatment, and then did not seek additional medical services until visiting Dr. Utter in late 1985. He further testified that although he did not seek treatment during the interim, his condition worsened as a result of his work for the second employer, eventually forcing him to leave the job.

On cross-examination, claimant admitted having an automobile accident on October 3, 1985, four days before he left work. The car he was driving left the road and struck a telephone pole, resulting in extensive damage to the car. Claimant further testified that he had mentioned the motor vehicle accident to all of the physicians he subsequently visited.

The Referee found claimant's testimony "not trustworthy for several reasons." He seriously questioned claimant's representation that he discussed his auto accident with his physicians. The medical records and reports of the physicians are silent with regard to a motor vehicle accident. Despite the Referee's reservations, he found the claim to be compensable. His findings largely relied on the reports of Dr. Utter and the Western Medical Consultants panel which, based on claimant's history, supported an aggravation claim.

In order to establish a compensable aggravation, claimant must prove that his condition has worsened since the last arrangement of compensation, and that the worsening is materially related to the compensable injury. ORS 656.273(1); Smith v. SAIF, 302 Or 396 (1986). Although we agree with the Referee that the medical record, as it is written, supports claimant's claim, that record was heavily reliant on claimant's history. His representations and/or omissions to the various physicians, therefore, were of great importance.

On this record, we find it more probable than not that claimant did not advise his doctors that he had had a serious motor vehicle accident approximately three weeks before he sought treatment in October 1985. Although claimant testified that he told the physicians, their records and reports are silent in that regard. Had the physicians been advised of the accident, their opinions may have differed. Because they were not so advised, however, we cannot know the effect, if any, that that knowledge would have had. In any event, the evidentiary value of the doctors' opinions is greatly reduced because of the incomplete history on which they were based. See Moe v. Ceiling Systems, Inc., 44 Or App 429 (1980); Hammons v. Perini Corp., 43 Or App 299 (1979). Much of the remaining evidence comes from claimant's testimony, which the Referee found not trustworthy. Consequently, we are unpersuaded that claimant has suffered a compensable aggravation. The Referee's holding in that regard will be reversed.

ORDER

The Referee's order dated July 18, 1986 is reversed in part and affirmed in part. That portion of the order that set aside the insurer's denial of claimant's aggravation claim is reversed and the denial is reinstated. The remainder of the order is affirmed. Claimant's attorney is awarded a reasonable attorney fee of $500 for services on Board review concerning the thermography issue, to be paid by the insurer.

ROBERT L. CAVIL, Claimant
Galton, et al., Claimant's Attorneys
Rankin, et al, Defense Attorneys

WCB TP-87011
August 14, 1987
Third Party Order

Claimant has petitioned the Board to resolve a dispute as to the reasonableness of a proposed settlement of claimant's civil action against a third party allegedly responsible for his compensable injury. See ORS 656.154; 656.578. A conflict has arisen concerning the proposed settlement and what may be a just and proper distribution of the settlement's proceeds. The Board has jurisdiction to resolve such conflicts. ORS 656.587; 656.593(3).

After reviewing this matter, evaluating the parties' respective assessments of the third party action, and exercising our own independent judgment, we conclude that the proposed settlement of $18,000 is reasonable. Having made that determination, we turn to the dispute concerning the distribution of the settlement's proceeds.

Claimant requests that the proceeds be distributed in accordance with the distribution formula contained in ORS 656.593(1). The paying agency objects to such a distribution, suggesting that its share of the proceeds equal $10,917. This figure is apparently less than one-third of the paying agency's present lien.

The paying agency further recommends that claimant's recovery and his attorney's fee be reduced to amounts that approximate their respective shares if the settlement had been $15,000, rather than the $18,000 figure. The paying agency contends that this is a fair proposal because: (1) claimant was initially willing to settle the case for the lower figure; (2) under the agency's proposed distribution, claimant's and his attorney's share of the $18,000 settlement would be roughly the same as they would have realized under a $15,000 settlement; and (3) the agency's share of the settlement would maximize its return and recoup its current medical costs.

The statutory formula for distribution of a third party recovery obtained by judgment, ORS 656.593(1), is generally applicable to the distribution of a third party recovery obtained by settlement. Marvin Thornton, 34 Van Natta 999 (1982). Moreover, since it is our policy to avoid making "equitable distributions on an ad hoc basis," we usually refrain from resolving distribution conflicts in a manner that would depart from the statutory formula. Id. at 1002. Yet, on rare occasions, circumstances may justify a departure from the statutory distribution formula. For example, in Robert T. Gerlach, 36 Van Natta 293 (1984), we reduced a paying agency's lien to "in effect, reconstruct an agreement the parties substantially entered into, but which subsequently fell apart primarily due to an unfortunate failure of communication." Id. at 296.

Here, circumstances do not justify our departure from the statutory distribution formula. Rather than presenting unusual circumstances, the paying agency is advocating a position which is available to any paying agency or claimant in a dispute involving the distribution of a third party recovery. To wit, that it would be more equitable to order a distribution that results in its receipt of a larger portion of the proposed third party settlement. As we stated in Thornton, if such arguments were permitted, in the long run the results would probably be random, standardless, and thus inequitable. We continue to adhere to this reasoning, which is further expressed as follows:

> "In order to encourage third party actions, it is, therefore, preferable to adopt a policy which facilitates - or at least does not retard - settlement of such actions. We believe that the doctrine of equitable apportionment of third party settlements would retard the settlement of third party actions by injecting significant

uncertainty into the negotiation process. Under the statutory distribution formula, the parties generally know where they stand. If, instead, the claimant, claimant's attorney and workers compensation insurer knew only that each would receive that portion of the settlement that the current Board then regarded as equitable, settlement of a third party action would at least be more difficult, if not impossible." 34 Van Natta at page 1002.

For the reasons expressed herein, we find that a distribution of proceeds of the settlement in accordance with ORS 656.593(1) is just and proper. Accordingly, claimant's petition is granted.

IT IS SO ORDERED.

MICHAEL T. FLANNERY, Claimant
Vick & Gutzler, Claimant's Attorneys
Schwabe, et al., Defense Attorneys

WCB 86-05220
August 14, 1987
Order on Review (Remanding)

Reviewed by Board Members Lewis and McMurdo.

Claimant requests review of Referee Leahy's order that dismissed his request for hearing. On review, claimant argues that we should set aside the Referee's order and remand this matter for a decision on the merits.

In February 1975, claimant sustained a compensable low back injury. After receiving conservative treatment from several physicians his claim was closed by a Determination Order in October 1976. Thereafter, his claim was reopened several times and claimant was eventually awarded 45 percent unscheduled permanent disability by Determination Orders and stipulations.

In February 1985, claimant began to treat with Dr. Smith, a neurologist. One month later, the insurer informed claimant that he had treated with more than five physicians and that it would only pay for Smith's initial examination. After receiving another billing from Smith, the insurer issued a formal denial in April 1985, stating:

> "Dr. Donald Smith's office recently billed us for a facet injection which was administered on April 9, 1985. In my letter of March 18, 1985, I specifically stated that we would be responsible for the initial office visit of February 22, 1985; however, we will not be responsible for further treatment. Therefore, we must deny payment of services rendered on April 9, 1985, in the amount of $150." (emphasis added).

Claimant did not timely appeal the denial. Nonetheless, he continued to treat with Dr. Smith. Although bills for Smith's services were submitted to the insurer, they were not paid. Consequently, claimant filed a request for hearing in April 1986, challenging the insurer's "refusal to pay Dr. Smith."

The insurer moved for dismissal of claimant's request for hearing. After considering the parties' arguments, the Referee issued an Order of Dismissal, stating: "the denial forecloses all treatment by Dr. Smith."

We disagree with the Referee's dismissal of claimant's request for hearing. The Referee interpreted the denial as a denial of all future treatment from Dr. Smith. We do not disagree that it is possible to interpret the denial expansively. However, in keeping with our decision in Patricia M. Dees, 35 Van Natta 120 (1983), we interpret the denial narrowly as applying solely to Dr. Smith's treatment of April 9, 1985.

Here, claimant specifically requested a hearing on the issue of medical services and the insurer's failure to pay Dr. Smith. Claimant concedes that he is time-barred from contesting the insurer's refusal to pay for Dr. Smith's April 9, 1985 treatment, but not Smith's subsequent treatments. As in any case involving a "de facto" denial of medical services, a claimant may request a hearing at any time and seek to prove that the disputed services are necessary and reasonably related to the industrial injury. ORS 656.245(1); Wetzel v. Goodwin Bros., 50 Or App 101 (1981).

Claimant has requested a hearing and is entitled to present evidence concerning the compensability of Dr. Smith's treatment beyond April 9, 1985. Therefore, we remand this case to the Referee for the taking of evidence concerning this issue.

ORDER

The Referee's Order of Dismissal dated November 24, 1986, is vacated and this matter is remanded to the Hearings Division for further proceedings consistent with this order.

RONALD McCARTY, Claimant
Peter O. Hansen, Claimant's Attorney
Roberts, et al., Defense Attorneys

WCB 86-02529
August 14, 1987
Order on Review

Reviewed by Board Members Ferris and Lewis.

Claimant requests review of that portion of Referee Tenenbaum's order that upheld the insurer's denial of his aggravation claim for a right knee injury. On review, the issue is aggravation.

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

After conducting our de novo review of the medical and lay evidence, we are not persuaded that claimant's compensable condition has worsened since the last award or arrangement of compensation. ORS 656.273(1). Specifically, claimant has not met the "increased loss of use" standard adopted by the Court of Appeals for aggravation claims in scheduled disability cases. International Paper Co. v. Turner, 84 Or App 248, 250 (1987). Alternatively, claimant has not satisfied the "less able to work" standard affirmed by the Supreme Court in Smith v. SAIF, 302 Or 396, 399 (1986). Accordingly, we conclude that the insurer's denial of claimant's aggravation claim should be upheld.

ORDER

The Referee's order dated November 13, 1986, as supplemented herein, is affirmed.

HAROLD R. MOORE, Claimant
Coons & Cole, Claimant's Attorneys
E. Jay Perry, Defense Attorney

WCB 86-02011
August 14, 1987
Order on Review

Reviewed by Board Members McMurdo and Lewis.

Claimant requests review of Referee T. Lavere Johnson's order that upheld the insurer's denial of his industrial injury claim relating to his low back and refused to assess a penalty for a claims processing violation. The issues are the timeliness of claimant's claim, compensability and penalties.

Claimant slipped and fell while leaving work in early September 1985. The fall was witnessed by a nonsupervisory coworker. Claimant felt that he had knocked the wind out of himself, but did not think that he had otherwise hurt himself. He returned to work for the next month and testified that his back was sore. He did not file a claim or tell anyone at work about this.

Later the same month, claimant began to experience dizzy spells and generalized neurological symptoms and sought medical treatment. In the course of evaluating this problem (which the parties agree is not related to the fall at work), a CT scan of the low back was performed and a herniated disc at L3-4 was identified. Claimant's treating neurosurgeon, Dr. Golden, has since opined that this disc herniation was the result of the fall at work.

The Referee concluded that claimant's claim was compensable on the merits, but upheld the insurer's denial on the ground that the claim had not been timely filed. The Referee also concluded that the insurer had unreasonably failed to disclose claims information in a timely fashion and awarded claimant's attorney a fee on this issue under the rule of Spivey v. SAIF, 79 Or App 568, 572 (1986). He did not award a penalty, however, because he had ruled the claim untimely and thus no compensation was due. See ORS 656.262(10).

On Board review, claimant argues that his claim should not be barred as untimely because he had good cause for not filing a claim sooner and, in any event, the insurer was not prejudiced by the delay in filing. See ORS 656.265(4). If the claim is found timely and compensable, he also requests a penalty for the insurer's disclosure violation.

We agree with claimant's argument on the issue of prejudice to the insurer. The claim was filed only two months late. This delay did not materially hamper the insurer's ability to investigate the claim or appreciably dim the memories of the witnesses for any significant facts. On the merits, we agree with the Referee that the claim is compensable. We also agree with the Referee's conclusion that the insurer unreasonably failed to provide disclosure of information pertaining to claimant's claim and conclude that a penalty of 25 percent is appropriate on all compensation due on or before February 26, 1986, the date when the disclosure violation occurred. See OAR 438-07-015(2).

ORDER

The Referee's order dated November 24, 1986 is affirmed in part and reversed in part. Those portions of the order that found claimant's claim untimely filed, dismissed claimant's request for hearing and upheld the insurer's denial dated February 3, 1986 are reversed. The claim is remanded to the insurer for acceptance and processing. In addition, the insurer shall pay to claimant a penalty of 25 percent of all compensation due on or before February 26, 1986. That portion of the Referee's order that awarded claimant's attorney an attorney fee of $350 in connection with the insurer's disclosure violation is affirmed. In connection with the denial, claimant's attorney is awarded $1,200 for services at the hearing level and $600 for services on Board review, to be paid by the insurer.

SANDRA G. NEAL, Claimant
Charles D. Maier, Claimant's Attorney
SAIF Corp Legal, Defense Attorney

WCB 85-10414 & 85-08084
August 14, 1987
Order on Review

Reviewed by Board Members McMurdo and Lewis.

The SAIF Corporation requests review of Referee Michael Johnson's order that: (1) set aside its denial of claimant's occupational disease claim for carpal tunnel syndrome; and (2) awarded claimant 20 percent (64 degrees) unscheduled permanent disability for her back condition, in lieu of the Determination Order's award of no unscheduled permanent disability. The issues are compensability and extent of unscheduled permanent disability.

We affirm that portion of the Referee's order that found claimant's carpal tunnel condition compensable. We reverse that portion of the order that awarded 20 percent unscheduled permanent disability for claimant's back condition.

In March 1985 claimant suffered a compensable injury to her upper back while working as a custodian. Dr. Cummings, chiropractor, diagnosed "acute cervical thoracic lumbar strain with attending myalgia." In April 1985 Dr. Bolin, chiropractor, concluded that claimant had suffered a cervical, thoracic, lumbar strain by history. Dr. Bolin reported that she had minimal impairment, which he did not expect to be permanent. In May 1985 Independent Chiropractic Consultants diagnosed: (1) cervical strain/sprain resolving; and (2) lumbar strain resolved. The Consultants concluded that claimant should have continued care for four to six weeks at which time she would experience significant improvement. Claimant continued regular treatment with Dr. Cummings.

In June 1985 claimant attended the Callahan Center for a Vocational Assessment Program. Dr. Miller, psychologist, examined claimant and concluded that psychological factors were affecting her condition. Dr. Schwan, osteopath, diagnosed: (1) cervical sprain; (2) lumbodorsal sprain; and (3) rule out L4-5 herniated intervertebral disc. He felt claimant was sincere in her desire to return to work, but felt she still had unresolved medical problems. On September 4, 1985 Dr. Cummings released claimant for regular work with unspecified limitations.

On September 12, 1985 claimant injured her back in a car accident. Claimant was treated in the Emergency Room and

Dr. Strand diagnosed cervical strain. On September 18, 1985 Dr. Cummings diagnosed: (1) "cervical cranial syndrome and displacement of cervical disc, accompanied with cervical myalgia, cervical neuralgia, cervical polymyositis, kinesialgia, hypo-kinesia, cervical whip-lash injury sprain or strain"; (2) "displacement of thoracic intervertebral disc with attending pain in the thoracic spine"; (3) "lumbar intervertebral disc syndrome with lumbo-sacral sprain/strain"; and (4) segmental disfunction or subluxation of the cervical neck, segmental disfunction or subluxation of the thoracic spine, segmental disfunction or subluxation of the lumbar spine." All of these injuries were directly related to the automobile accident and no mention was made of her prior compensable injury. On September 20, 1985, Dr. Cummings reported to SAIF that claimant was released to regular work on September 4, 1985 and was medically stationary on September 11, 1985. In late October 1985, Dr. Cummings informed the automobile insurer that all charges after September 12, 1985 were due solely to the automobile accident.

In October 1985 Dr. Cummings informed SAIF that, with regard to claimant's work injury, she needed only palliative treatment on an infrequent basis "predominantly in the cervical neck, but to a far lesser degree in the thoracic and lumbar spine which were medically resolved several weeks before." He further reported that "[t]here were no indications of limitations therefore she was released to work full time September 4, 1985." In November 1985 Dr. Bolin diagnosed: 1) inertia sprain/strain of the cervical, thoracic spine; and (2) left sacroiliac strain and fixation. Dr. Bolin concluded that September 11, 1985 was an appropriate date for claimant to be found medically stationary with regard to her work injury. Concluding that she was not medically stationary with regard to the car accident, Dr. Bolin stated that she had mild to moderate impairment and needed continued care.

In December 1985 a Determination Order issued awarding claimant no permanent disability. On December 18, 1985 Dr. Cummings reported to SAIF that claimant's work injury had made her more susceptible to aggravation and, therefore, she had incurred permanent impairment. No mention is made of the effect of the automobile accident or its relation to the work injury. On January 7, 1986 Dr. Peterson, chiropractor, examined claimant on behalf of the automobile insurer. Dr. Peterson concluded claimant had sustained a mild cervical, thoracic and lumbar strain with significant functional overlay. He did not specify what residuals were related to the automobile accident and what were related to claimant's industrial injury. On January 15, 1986, Dr. Cummings wrote the automobile insurer and reported that he expected to release claimant from further treatment as of February 15, 1986. He reported that claimant may have some mild form of permanent partial spinal impairment, but that would have to be determined as of her final examination. Again no mention was made of the industrial injury.

On February 10, 1986 Dr. Cummings reported to SAIF that claimant did have permanent impairment as a result of her work injury. Dr. Cummings stated that "[b]ecause of the traumatic [work] injury that the patient received in the accident, she is precluded from heavy lifting, sitting or standing for long periods of time." He also recommended vocational retraining to an occupation other than custodial work. No mention is made of what

effect claimant's automobile accident had on her current disability. Subsequently, claimant settled her claim with the automobile insurer for payment of medical services and $6,500 in damages.

At hearing, claimant testified that her back problems had returned to the same condition as before the car accident. She reported difficulty sitting or standing for extended periods of time and restricts her twisting, bending and stooping. She voluntarily limits her lifting to 15 pounds.

In awarding the claimant unscheduled permanent disability, the Referee concluded that Dr. Cummings had successfully differentiated between the residuals from the work injury and the automobile accident. We disagree.

Claimant must prove by a preponderance of the evidence that her current impairment is related to her industrial injury. See ORS 656.214(5). Here, Dr. Cummings has indicated that claimant was medically stationary on September 11, 1985. Furthermore, in September 1985 Dr. Cummings reported to the automobile insurer that claimant's need for treatment after September 12, 1985 was all related to the automobile accident. However, in October 1985 he reported to SAIF that, with regard to the industrial injury, claimant needed only infrequent palliative care for her cervical condition and that her thoracic and lumbar conditions had basically resolved. Dr. Cummings placed no limitations on claimant. None of his subsequent reports to the automobile insurer mention the industrial injury.

Yet, in February 1986 Dr. Cummings reported to SAIF that claimant's condition due to the work injury was "relatively serious" and that claimant had significant limitations. Dr. Cummings report again does not mention the automobile accident or what effect it may have had on claimant's back. Further, Dr. Cummings fails to explain the radical change in his opinion from the October 1985 assessment of claimant's impairment to the February 1986 assessment. Consequently, we are unable to rely on Dr. Cummings' evaluation of claimant's condition and conclude from the remaining evidence that claimant has failed to establish that her current impairment is related to her industrial injury. As a result, claimant is not entitled to an award of permanent disability.

ORDER

The Referee's order dated July 18, 1986 is affirmed in part and reversed in part. The Referee's award of permanent disability is reversed. In lieu of that portion of the order that awarded claimant 20 percent (64 degrees) unscheduled permanent disability for her back condition, claimant is awarded no unscheduled permanent disability. The remainder of the order is affirmed. For prevailing on the compensability issue, claimant's attorney is awarded $400 as a reasonable attorney fee, to be paid by the SAIF Corporation.

ERNEST W. BOTEFUR, Claimant
Malagon & Moore, Claimant's Attorneys
Dennis Ulsted (SAIF), Defense Attorney

WCB 85-00470
August 17, 1987
Order on Remand (Remanding)

Reviewed by Board Members McMurdo and Lewis.

This matter is before the Board on remand from the Court of Appeals. Botefur v. City of Creswell, 84 Or App 627 (1987). The court has mandated that this matter be remanded to the Referee for: (1) an award of temporary total disability from December 14, 1984 to February 5, 1985; (2) a determination of a penalty and attorney fees; and (3) a determination of whether claimant is entitled to temporary total disability for any period between the filing of the claim and December 14, 1984.

Accordingly, this matter is remanded to Referee Tenenbaum for action consistent with the court's opinion.

CHARLES R. LIES, Claimant
Philip H. Garrow, Claimant's Attorney
Alan Ludwick, Defense Attorney

WCB 86-10833
August 17, 1987
Interim Order of Remand

Claimant has requested review of Referee Nichols' order which was entered on March 2, 1987. The hearing in this matter was held on December 15, 1986 in Bend, Oregon. The hearing was electronically recorded. Following written closing arguments, the record was eventually closed. In accordance with ORS 656.295(3), a transcription of the proceedings was requested.

In response to this request, the hearing reporter has advised the Board that a cassette tape which recorded the last portion of the hearing has been misplaced. The last portion of the hearing apparently involved the testimony of Sandra Tate, a claims examiner for the SAIF Corporation, and Mike Mehring, a SAIF investigator. The parties are in disagreement as to the relevancy of these individuals' testimony to the issues currently on appeal.

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 testimony of Ms. Tate and Mr. Mehring. The Referee shall make every reasonable effort to ensure that the testimony provided at the hearing is the same or similar to that taken during the prior proceedings. No new or additional evidence should be presented.

We retain jurisdiction over this matter. Upon completion of the reconvened hearing, the Referee shall obtain and forward a copy of the transcription of the proceedings to the Board within thirty (30) days of the hearing date. In addition, the Referee shall provide an interim order on remand, advising the Board of the effect, if any, the testimony has had upon her prior order. Once the Board receives the transcript, copies will be provided to the parties and a briefing schedule will be implemented.

IT IS SO ORDERED.

MANUEL PEREZ, Claimant
Vick & Gutzler, Claimant's Attorneys
Merrily McCabe (SAIF), Defense Attorney

WCB 84-10951
August 17, 1987
Order on Reconsideration

The SAIF Corporation requests reconsideration of those portions of our Order on Review dated July 23, 1987 which affirmed the Referee's award of 10 percent unscheduled permanent partial disability for his low back and set aside its denial of medical services relating to the low back. It renews its argument that claimant's award of permanent partial disability should be eliminated and that its medical services denial should be upheld. In the alternative, it asks that we clarify our order by specifying the precise condition or conditions for which it is responsible.

Effective this date, we adhere to and republish our previous order with the following clarification. The SAIF Corporation is responsible for a chronic musculoligamentous strain of claimant's left lower back with associated radiculopathy in the left lower extremity.

IT IS SO ORDERED

MARY M. CHACARTEGUI, Claimant
Pozzi, et al., Claimant's Attorneys
Roberts, et al., Defense Attorneys

WCB 85-06991
August 19, 1987
Order on Reconsideration

The insurer has requested reconsideration of that portion of our Order on Review dated July 30, 1987 which modified the medically stationary date specified in the Determination Order and affirmed by the Referee. In its request, the insurer asks the Board to authorize it to offset the temporary disability compensation it overpaid pursuant to the Determination Order. We authorize the requested offset with the understanding that claimant's award of permanent total disability is effective as of June 15, 1984. As supplemented herein, we adhere to and republish our previous order, effective this date.

IT IS SO ORDERED.

HERBERT PARKER, Claimant
Francesconi & Cash, Claimant's Attorneys
Roberts, et al., Defense Attorneys

WCB TP-87006
August 19, 1987
Third Party Order

Claimant has petitioned the Board to resolve a dispute concerning the validity of the insurer's lien against any proceeds resulting from claimant's cause of action for medical negligence. Asserting that a disputed claim settlement has foreclosed the insurer from seeking reimbursement for its claim costs, claimant contends that the lien is invalid. We agree.

While working as a warehouseman, claimant was injured when a wheel fell from a flat car and landed on his right foot. Approximately five days later, he advised his employer of the incident and sought medical treatment. His condition was diagnosed as an infection and traumatic lesion of the right foot, with a compound fracture of the right big toe. Relating claimant's condition to his work injury, his treating physician recommended antibiotics and bedrest. Another five days later, claimant returned to his physician, complaining of symptoms which were determined to be attributable to an acute infection with ascending cellulitis of the right foot. Gangrene was subsequently detected, necessitating amputation of claimant's right leg below the knee.

Claimant received temporary disability benefits for approximately 14 weeks. Thereafter, the insurer issued a Notice of Closure, concluding that claimant had sustained no permanent disability. Coinciding with the administrative closure, the insurer issued a denial letter. Except for acknowledging its acceptance of "the fracture of the toe only," the insurer denied responsibility for any future claims for benefits. Specifically, the insurer denied responsibility for claimant's preexisting diabetes, circulatory problems, and heart failure, as well as his resulting amputation and infection "due to the five days before treatment."

Claimant requested a hearing. However, before a hearing was convened, the parties entered into a Disputed Claim Settlement. In return for a stated sum, claimant agreed to dismiss his request for hearing with prejudice. The parties further agreed that the Notice of Closure and the insurer's denial would "remain in full force and effect." The settlement closed as follows:

> "(4) This settlement resolves all issues of temporary disability, permanent disability, future medical care and treatment, aggravation rights, and all other workers' compensation benefits associated with claimant's right lower leg and foot amputation and its sequala on a disputed claim basis."
>
> "(5) Acceptance of this settlement means that no present or future compensation or medical benefits will be allowed under the Workers' Compensation Act for claimant's right lower leg and foot amputation and its sequala."

Following Referee approval of the settlement, claimant initiated a civil action against two physicians. He sought damages, alleging medical negligence. Specifically, claimant contended that the physicians had failed to adequately diagnose and/or treat his foot condition. Upon learning of claimant's suit, the insurer provided notice of its intention to assert a third party lien.

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, the worker shall elect whether to recover damages from such third person. ORS 656.578. If an injury to a worker is due to the negligence or wrong of a third person not in the same employ, the injured worker may elect to seek a remedy against the third person. ORS 656.154. 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.

Claimant objects to the insurer's action, contending that the disputed claim settlement conclusively established that there was no compensable infection or amputation. The insurer concedes that no lien exists concerning conditions which relate to those portions of the claim which the parties have previously

agreed is not compensable. However, the insurer argues that it may assert its lien against that portion of the claim which was accepted, i.e., the fractured toe, resulting medical treatment and temporary disability compensation.

We agree that the insurer could assert a lien for its claim costs against any proceeds from a third party action which resulted from claimant's compensable injury. Yet, the parties have expressly agreed that the compensable injury was the "fracture of the toe only," and not the "resulting amputation and infection due to the five days before treatment." As previously noted, the third party suit involves allegations of negligence commencing with the care and treatment of claimant's infected right foot condition and the eventual amputation of his right lower leg. Inasmuch as the parties have stipulated that those portions of the claim were not compensable, we conclude that the third party lien is invalid.

The insurer further asserts that it is entitled to reimbursement of its temporary total disability payments because, "but for" the alleged medical negligence, claimant's recovery would have been substantially shorter. Such an assertion is speculative. Moreover, the parties' affirmation of the Notice of Closure resolved this matter. Since the claim closure specifically identified claimant's time loss compensation and because the parties had agreed that the compensable injury was a "fracture of the toe only," it has been conclusively established that claimant's temporary disability compensation resulted from his compensable injury and not from the noncompensable alleged medical negligence.

IT IS SO ORDERED.

DANNY R. AKERS, Claimant
Roberts, et al., Defense Attorneys

WCB 86-11855
August 21, 1987
Order Denying Motion to Dismiss

The insurer has moved the Board for an order dismissing claimant's request for Board review on the grounds that the request was untimely filed and that copies were not timely mailed to the parties. The motion is denied.

The Referee's order issued June 18, 1987. On July 17, 1987, the Board received a hand-delivered letter from claimant, requesting review of the Referee's order. In the letter, claimant represented that copies of the request "have been sent to all the parties in concern." Listed as "parties in concern" were the names and addresses of the employer, its insurer, and the insurer's attorney. A computer-generated letter acknowledging the request for Board review was mailed to the parties on July 22, 1987. The insurer's counsel promptly received the Board's letter, but did not receive a copy of the request for review from claimant until July 27, 1987. Inasmuch as the insurer's counsel's staff did not retain the envelope in which the copy of claimant's request was contained, they were unable to specifically determine when the notice was mailed.

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

Board and copies of the request shall be mailed to all parties to the proceeding before the Referee. ORS 656.295(2). Compliance with ORS 656.295 requires that statutory notice of the request for review be mailed or actual notice be received within the statutory period. Argonaut Insurance Co. v. King, 63 Or App 847, 852 (1983).

Here, claimant timely filed a request for Board review of the Referee's order. See ORS 656.289(3); OAR 438-05-040(4); 438-11-005(2). Furthermore, accompanying the request was claimant's representation that copies "have been sent to all the parties in concern." The insurer's counsel acknowledges receipt of a copy of the request for review, albeit some ten days after the original request was filed. Under these circumstances, we are persuaded 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. Therefore, we conclude that we have jurisdiction to consider his request for Board review.

Accordingly, the insurer's motion to dismiss is denied.

IT IS SO ORDERED.

ROBERT W. ASHLEY, Claimant
David C. Force, Claimant's Attorney
Pamela Schultz (SAIF), Defense Attorney

WCB 84-10040
August 21, 1987
Order on Reconsideration

Claimant has requested reconsideration of those portions of our Order on Review dated July 30, 1987 that: (1) construed his submission of documents generated after the date of the hearing as a request for remand; and (2) awarded his attorney a fee of $650 for services on Board review. In his request for reconsideration, claimant states that he did not submit the documents as evidence for inclusion in the record, but "merely to demonstrate that some of the arguments and statements in the insurer's opening brief were . . . incompletely accurate." We note that claimant's response brief on Board review contains a "motion to supplement the record" in connection with the submitted documents. The motion, however, does state that claimant did not desire a remand and that the Board should not consider the documents unless it granted his motion to supplement the record. We delete, therefore, that portion of our Order on Review that construed claimant's submission of documents as a request for remand.

With regard to claimant's motion to supplement the record, the Board is without authority to supplement the record developed by the Referee. See ORS 656.295(5). Claimant's motion to supplement the record, therefore, is denied. On the attorney fee issue, we conclude on reconsideration that claimant's attorney was appropriately compensated.

Accordingly, the motion for reconsideration is granted and our former order withdrawn. On reconsideration, as amended herein, the Board adheres to and republishes its previous order, effective this date.

IT IS SO ORDERED.

SHAREN L. EVANS, Claimant
Vick & Gutzler, Claimant's Attorneys
Meyers & Terrall, Defense Attorneys
Tooze, et al., Defense Attorneys

WCB 85-14990 & 86-00724
August 21, 1987
Order on Reconsideration

The Hartford Insurance Group (Hartford) has requested clarification of our Order on Review dated June 30, 1987. Our order reversed that portion of the Referee's Opinion and Order that found Hartford responsible for claimant's low back condition. Our order further directed Frito-Lay, a self-insured employer, to process claimant's claim and to reimburse Hartford for claims costs. We then affirmed the remainder of the Referee's order, which included a portion directing Hartford to pay claimant's attorney a fee for services at hearing.

In its response to Hartford's request for reconsideration, Frito-Lay asks us to reconsider our order as it pertains to the merits of our responsibility decision. It asserts that Hartford is, in fact, responsible for claimant's current condition, and that we should so find on reconsideration.

The parties' requests for reconsideration are granted, and we withdraw our prior order. On reconsideration, we adhere to our order as it pertains to the issue of responsibility. We agree with Hartford, however, that that portion of our order regarding the payment of claimant's attorney fee at hearing needs clarification.

Our affirmation of the Referee's award of attorney fees was inadvertent. Because Frito-Lay was found responsible for claimant's condition, it must now pay his attorney fee for services at hearing.

Now, therefore, having granted the parties' request for reconsideration, we modify our prior order. Frito-Lay is ordered to pay the attorney fee awarded by the Referee for services at hearing. Except as herein modified, we adhere to and republish our prior order, effective this date.

IT IS SO ORDERED.

RUTH E. FOX, Claimant
Bischoff & Strooband, Claimant's Attorneys
Rick Barber (SAIF), Defense Attorney

WCB 85-04829
August 21, 1987
Order on Review

Reviewed by Board Members Lewis and McMurdo.

Claimant requests review of Referee Wasley's order that: (1) awarded 30 percent (96 degrees) unscheduled permanent disability for a back condition, in lieu of a Determination Order's award of 15 percent (48 degrees); and (2) upheld the SAIF Corporation's refusal to authorize thermography tests. The issues are extent of unscheduled disability and medical services.

We affirm that portion of the Referee's order that upheld SAIF's refusal to authorize thermography tests. We modify the Referee's order with respect to claimant's extent of unscheduled permanent disability.

Claimant, 58 years of age at the time of hearing, sustained a compensable back injury in January 1985. Shortly

thereafter, she began to treat with Dr. Hoyt, a chiropractor. Hoyt diagnosed a "falling injury to the spine and associated neurology." Eventually, Hoyt restricted claimant to no lifting, bending, stooping, or twisting.

In August 1985, claimant was examined by Dr. Kendrick, a neurologist. Kendrick reported that claimant was able to work, provided she did not engage in repetitive bending or lifting in excess of 20 to 25 pounds.

A Determination Order issued in October 1985, awarding claimant 15 percent unscheduled permanent disability.

The Orthopaedic Consultants examined claimant in May 1986. The Consultants diagnosed, inter alia: (1) cervicodorsal strain superimposed on degenerative disc disease; and (2) lumbar strain superimposed on osteoporosis. With respect to claimant's cervical area, the Consultant's reported "mildly moderate" impairment, with "mild" impairment due to the industrial injury. Regarding claimant's low back, the Consultants reported "mild" impairment, with "minimal" work-related impairment.

Claimant has completed 11 years of schooling and has worked primarily in the restaurant business. Her duties have ranged from waitress to owner. At the time of her compensable injury, she was working as a salad maker. She credibly testified that her job required lifting sacks of vegetables weighing up to 100 pounds, as well as bending and stooping. She feels that she can no longer perform those activities or lift more than five pounds.

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

Following our de novo review of the medical and lay evidence, which includes claimant's credible testimony concerning her disabling pain and physical limitations, and considering the relevant social and vocational factors, we conclude that a 45 percent unscheduled disability award appropriately compensates claimant for her lost earning capacity resulting from the compensable back injury.

ORDER

The Referee's order dated August 6, 1986 is affirmed in part and modified in part. That portion of the Referee's order that upheld the SAIF Corporation's refusal to authorize thermography treatments is affirmed. That portion of the Referee's order that awarded claimant an additional 15 percent (48 degrees) unscheduled permanent disability is modified. In addition to claimant's previous permanent disability awards, claimant is awarded 15 percent (48 degrees) unscheduled permanent disability, for a total of 45 percent (144 degrees) unscheduled permanent disability. Claimant's attorney is allowed 25 percent of the additional compensation granted by this order. However, the total of claimant's attorney's fee allowed by the Referee and the Board shall not exceed $3,000.

DEBBIE K. GOEDERT, Claimant
Rick Barber (SAIF), Defense Attorney

WCB 85-06990
August 21, 1987
Order Denying Motion to Dismiss

The SAIF Corporation has moved the Board for an order dismissing claimant's request for review on the grounds that the request was untimely filed. The motion is denied.

The Referee's order issued June 26, 1987. A request for review was mailed to the Board on Monday July 27, 1987. The request was submitted by claimant's former counsel, as a courtesy to claimant and to avoid foreseeable prejudice to her rights. See DR 2-110(A)(2). Copies of the request were also mailed to the employer and SAIF.

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). When computing time periods, if the last day falls on a Saturday, Sunday, or legal holiday, the period runs until the end of the next business day. OAR 438-05-040(4)(c).

Here, the Referee's order issued on June 26, 1987. The 30th day after June 26, 1987 was July 26, 1987, a Sunday. Claimant's request for Board review was mailed on Monday, July 27, 1987. Inasmuch as the request for review was mailed on the next business day following the end of the statutory 30-day period, we conclude that it was timely filed. Consequently, we have jurisdiction to consider claimant's request.

Accordingly, SAIF's motion to dismiss is denied.

IT IS SO ORDERED.

RUSSELL J. KNORR, Claimant
Charles D. Maier, Claimant's Attorney
Lester Huntsinger (SAIF), Defense Attorney

WCB 86-09136
August 21, 1987
Order of Dismissal

On July 29, 1987, Capital Contact Sports, a noncomplying employer, requested Board review of a Referee's order that issued April 27, 1987. The request for review is dismissed as untimely.

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).

Here, the SAIF Corporation, as processing agent for the noncomplying employer, and claimant timely requested Board review of the Referee's order. However, both parties subsequently moved to withdraw their appeals. Thereafter, dismissal orders issued on June 24, 1987 and June 30, 1987. Neither order has been abated, withdrawn, or appealed.

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 "stayed," withdrawn, or modified. International Paper Co. v. Wright, 80 Or App 444 (1986).

Here, the noncomplying employer's request for Board review of the Referee's order is clearly untimely. See ORS 656.289(3). Furthermore, because the Board's dismissal orders have neither been appealed, abated, "stayed," modified, nor "republished" within the statutory 30-day period, they have become final by operation of law. See ORS 656.295(8); International Paper Co. v. Wright, supra. Consequently, we conclude that we lack jurisdiction to consider the noncomplying employer's request.

Accordingly, the noncomplying employer's request for review is dismissed.

IT IS SO ORDERED.

EDWARD O. MILLER, Claimant
William Hensley, Claimant's Attorney
Rankin, et al., Defense Attorneys
Roberts, et al., Defense Attorneys

Own Motion 82-0210M
August 21, 1987
Own Motion Order on Remand

This matter is before the Board on remand from the Court of Appeals. Miller v. Coast Packing Company, 84 Or App 83 (1987). The court agreed with the Board that Brander Meat Company/Glen Falls Insurance Co. (Brander) was responsible for claimant's complex partial seizure disorder. However, the court concluded that neither claimant's paranoid psychosis nor his purported arm, neck, and shoulder syndrome condition were compensable. Consequently, the court reversed and remanded for an award of compensation consistent with its opinion.

We previously found Brander responsible for all three of the aforementioned conditions. Edward O. Miller, 37 Van Natta 174, 37 Van Natta 176 (1985). Because claimant's aggravation rights from his 1970 compensable head injury with Brander had expired and since we were persuaded that claimant was permanently disabled, we awarded permanent disability under our own motion authority pursuant to ORS 656.278. Edward O. Miller, 37 Van Natta 176, 180 (1985). However, our prior award of permanent disability was based upon the premise that claimant's underlying psychosis was causally related to his compensable 1970 injury. As noted above, the court has concluded that this condition is not compensable. Thus, other than the 1970 head injury, the compensable condition upon which to determine claimant's entitlement to permanent disability is his complex partial seizure disorder.

Following our review of this record, we are not persuaded that claimant has sustained a permanent loss of earning capacity resulting from either his compensable 1970 head injury or his complex partial seizure disorder. Accordingly, contrary to our February 22, 1985 determination, we conclude that claimant is not entitled to an award of permanent disability as a result of the consequences of his compensable 1970 head injury.

IT IS SO ORDERED.

MARVIN L. SIMS, Claimant
Coons & Cole, Claimant's Attorneys
Keith Skelton, Defense Attorney

Own Motion 84-0322M
August 21, 1987
Own Motion Order and Determination on Second Reconsideration

On July 30, 1987, we issued an Own Motion Order and Determination on Reconsideration. Pursuant to our order, claimant was awarded temporary total disability from February 18, 1984 through January 23, 1985 and from March 7, 1986 through claim closure pursuant to ORS 656.278. We further directed that these benefits were to be reduced by any wages and social security benefits claimant received during the aforementioned periods, as well as any benefits paid pursuant to a previous Own Motion Order dated May 29, 1987. Finally, as a reasonable attorney's fee, claimant's attorney was awarded 25 percent of the additional compensation granted by our July 30, 1987 order, not to exceed $450.

Claimant has requested reconsideration of our July 30, 1987 order, contending that his temporary total disability benefits should not be reduced by any social security benefits paid to him. He correctly notes that the only statutory authorization for offsetting social security benefits is set forth in ORS 656.209. This statute is limited to permanent, not temporary, total disability benefits. Consequently, we find no authority for the proposed offset.

Accordingly, claimant's request for reconsideration is granted and our July 30, 1987 order is withdrawn. On reconsideration, we amend our former order by deleting that portion which allowed claimant's temporary total disability benefits to be reduced by his social security benefits. Except for this modification, we adhere to and republish our July 30, 1987 order in its entirety, effective this date.

IT IS SO ORDERED.

FRANK M. BASKINS, Claimant
Vick & Gutzler, Claimant's Attorneys
Bottini & Bottini, Defense Attorneys
SAIF Corp Legal, Defense Attorney

WCB 86-01137 & 86-01136
August 26, 1987
Order on Review

Reviewed by Board Members McMurdo and Lewis.

The SAIF Corporation requests review of Referee Pferdner's order that: (1) set aside its denial of claimant's "new injury" claim for a neck and back condition; and (2) upheld SAFECO Insurance Co.'s denial of claimant's aggravation claim for the same condition. Claimant has not submitted a brief on review and has taken no position with regard to responsibility. The issue is responsibility.

The Board affirms that portion of the Referee's order that found SAIF responsible.

We modify that portion of the Referee's order that awarded an insurer-paid attorney fee. Petshow v. Farm Bureau Ins. Co., 76 Or App 563 (1985). Inasmuch as the record shows that claimant's counsel contributed to the issuance of an order designating a paying agent pursuant to ORS 656.307, we find that

claimant is entitled to an attorney fee to be paid from his compensation. Mark L. Queener, 38 Van Natta 882 (1986). Although this issue was not raised by the parties on review, we may make such disposition of the case as we determine to be appropriate. Destael v. Nicolai Co., 80 Or App 596, 600-01 (1986); Miller v. SAIF, 78 Or App 158, 161 (1986).

Accordingly, the Referee's award of a $500 insurer-paid attorney fee is modified to reflect an award of 25 percent of claimant's compensation, not to exceed $500.

ORDER

The Referee's order dated October 20, 1986 is affirmed in part and modified in part. In lieu of the Referee's award of a $500 insurer-paid attorney fee, claimant's attorney is awarded 25 percent of claimant's compensation, not to exceed $500, for services rendered prior to hearing in procuring an order designating a paying agent under ORS 656.307. The remainder of the Referee's order is affirmed.

ELWIN D. DISHNER, Claimant
Samuel A. Hall, Jr., Claimant's Attorney
SAIF Corp Legal, Defense Attorney

Own Motion 85-0103M
August 26, 1987
Own Motion Order

Claimant has requested that the Board exercise its own motion authority under ORS 656.278 and award him additional scheduled permanent disability for loss of use or function of the right arm stemming from a January 1976 compensable injury. Claimant's aggravation rights have expired. We deny the request.

The parties' April 20, 1987 stipulation dismissed claimant's pending hearing request from a September 11, 1986 Determination Order. In return for an additional award of temporary disability and scheduled permanent disability for loss of use or function to his left arm, claimant agreed to dismiss "all issues raised or raisable." Necessarily included within this resolution would be claimant's contention that he was entitled to an increased award of right arm scheduled permanent disability resulting from his compensable injury. Thus, in order to receive a further disability award, claimant must establish that his compensable condition has worsened since the stipulation, which marks the last arrangement of compensation. See generally, Weyerhaeuser Co. v. Bettin, 84 Or App 140 (1987).

Following our review of the record, we are not persuaded that claimant's compensable condition has worsened since the April 20, 1987 stipulation. Consequently, we conclude that his claim should not be reopened for a redetermination of the extent of disability, permanent or otherwise.

IT IS SO ORDERED.

SAMUEL L. HOKLAND, Claimant
Emmons, et al., Claimant's Attorneys
David O. Horne, Defense Attorney

WCB 85-12636
August 26, 1987
Order on Review

Reviewed by Board Members Lewis and McMurdo.

Claimant requests review of Referee Gruber's order that awarded claimant five percent (9.6 degrees) scheduled permanent partial disability for each arm and five percent (16 degrees) unscheduled disability for the head, neck and shoulders. The issue is extent of scheduled and unscheduled disability. We modify the Referee's award of unscheduled disability.

Claimant suffered a compensable injury to his head, neck shoulders and arms on June 30, 1983 while lifting and carrying foundation forms. He had been injured several times before, but had worked regularly prior to the June 1983 incident. Thereafter, he was examined by several physicians, including a chiropractor who opined that claimant would be unable to continue his heavy concrete laborer job. The remaining physicians stated, however, that claimant had full range of cervical motion and little in the way of objective impairment. With regard to impairment in claimant's arms, the doctors suggested mild bilateral carpal tunnel syndrome as a causal agent. The compensability of that condition was ultimately settled by way of a Disputed Claim Settlement, by which claimant received a sum of money in exchange for his agreement that the condition would thereafter remain in a denied status.

Claimant was 42 years of age at the time of the hearing. He completed the eighth grade and has limited skills in reading, writing and mathematics. His work history consists of heavy labor in sawmills and on construction jobs. No retraining had been effected at the time of the hearing. Although claimant's impairment does not appear to be significant, he testified that he has disabling pain.

The Referee awarded claimant five percent scheduled disability for each arm. In doing so, it appears that the Referee based the award on claimant's bilateral carpal tunnel syndrome. As has been noted, however, that condition was previously settled so that it is no longer a basis for an award. Thus, any scheduled award made by the Referee should have been for the effects of the 1983 compensable injury.

After reviewing the record, however, we find that claimant is entitled to the scheduled award ordered payable by the Referee. We find that as a result of the 1983 compensable injury, and over and above the impairment caused by claimant's carpal tunnel syndrome, claimant is entitled to five percent scheduled disability for each arm. The Referee's scheduled awards will, therefore, not be disturbed.

We modify the Referee's award of five percent unscheduled disability. As we have noted, while claimant's impairment is not substantial, the remaining factors we are to consider when determining unscheduled disability require that claimant's award be increased. Therefore, after considering claimant's age, education, work history, adaptability and other pertinent factors, we find that he is entitled to an increased award of 10 percent unscheduled disability, bringing his total award to 15 percent.

ORDER

The Referee's order dated November 5, 1986 is modified in part and affirmed in part. That portion of the order that awarded claimant five percent (16 degrees) unscheduled permanent partial disability for the head, neck and shoulders is modified. In addition to the Referee's award, claimant is awarded 10 percent (32 degrees) unscheduled disability, bringing his total award to 15 percent (48 degrees). The remainder of the Referee's order is affirmed. Claimant's attorney is allowed 25 percent of the increased compensation made payable by this order. However, the total attorney fees allowed by the Referee and the Board shall not exceed $3,000.

WILLIAM H. KAHL, Claimant
Bischoff & Strooband, Claimant's Attorneys
SAIF Corp Legal, Defense Attorney

WCB 82-10923 & 83-00907
August 26, 1987
Order on Remand

This matter is before the Board on remand from the Court of Appeals. Kahl v. SAIF, 86 Or App 203 (1987). The court reversed the Board's order that had dismissed claimant's request for review for lack of jurisdiction. Since the Board has jurisdiction to consider claimant's request for review, it will now be necessary to implement a briefing schedule.

Accordingly, claimant's appellant's brief shall be due within 21 days from the date of this order. The SAIF Corporation's respondent's brief shall be due within 21 days from the date of mailing of claimant's brief. Claimant's reply brief, if any, will be due within 14 days after the date of mailing of SAIF's brief.

IT IS SO ORDERED.

DANIEL A. LEE, Claimant
Bischoff & Strooband, Claimant's Attorneys
Cowling & Heysell, Defense Attorneys

WCB 86-05200
August 26, 1987
Order on Review

Reviewed by Board Members Ferris and McMurdo.

Claimant requests review of Referee Howell's order that: (1) upheld the insurer's denial of his occupational disease claim for bilateral carpal tunnel syndrome; and (2) declined to award permanent disability beyond the 30 percent (96 degrees) unscheduled permanent disability for claimant's back condition and 10 percent scheduled permanent disability for the loss of function of his right arm. The insurer seeks remand for consideration of an additional medical report. The issues are compensability, remand and extent of scheduled and unscheduled permanent disability.

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

On May 13, 1987 the insurer submitted an additional medical report dated December 12, 1986 for inclusion in the record. We treat the submission of documents on Board review as a request for remand. Judy A. Britton, 37 Van Natta 1262 (1985). However, the report does not indicate that the record has been incompletely or insufficiently developed to warrant remand. See ORS 656.295(5). Consequently, the request for remand is denied.

ORDER

The Referee's order dated October 27, 1986 is affirmed.

BARBARA J. REEVES, Claimant
Roll, et al., Claimant's Attorneys
Schwabe, et al., Defense Attorneys

WCB 85-11313
August 26, 1987
Order on Review

Reviewed by Board Members McMurdo and Lewis.

The insurer requests review of those portions of Referee Shebley's order that: (1) set aside its denial of claimant's occupational disease claim relating to bilateral carpal tunnel syndrome; and (2) held that claimant had sustained an aggravation of her compensable low back condition. The issues are the compensability of claimant's carpal tunnel condition, jurisdiction to decide the aggravation claim, aggravation and premature closure.

The Board affirms that portion of the Referee's order that set aside the insurer's denial of claimant's bilateral carpal tunnel syndrome. With regard to claimant's low back condition, we conclude that the claim for that condition was prematurely closed.

Dr. Berkeley, a consulting neurosurgeon, declared claimant medically stationary as of July 1, 1985 by checking the appropriate box on a claims processing form. The insurer submitted the claim for closure, but the Evaluation Division requested that the insurer obtain a current report from Dr. Cherry, claimant's treating orthopedist. In a chart note dated August 7, 1985, Dr. Cherry reported that claimant had experienced a marked increase in low back pain after moving activity which involved light to medium lifting. He prescribed further conservative treatment for her condition. He gave no indication that claimant was medically stationary or released for work. The Evaluation Division closed the claim by Determination Order on August 21, 1985. Under these circumstances, we conclude that claimant was not medically stationary at the time of claim closure and that the claim should be remanded to the insurer for further processing and proper closure. See ORS 656.268.

In light of our conclusion on the premature closure issue, we need not address the insurer's aggravation contentions.

ORDER

The Referee's order dated November 1, 1986 is affirmed in part and reversed in part. Those portions of the order that set aside the insurer's denial of claimant's claim for bilateral carpal tunnel syndrome and awarded an associated attorney fee are affirmed. That portion of the order requiring the insurer to reopen claimant's low back claim on an aggravation basis is reversed. The Determination Order dated August 21, 1985 is set aside as premature and the claim is remanded to the insurer for further processing and proper closure. In lieu of the attorney fee awarded by the Referee in connection with the aggravation issue, claimant's attorney is awarded 25 percent of the increased compensation granted by this order, not to exceed $1,200. Claimant's attorney is awarded $500 for services on Board review concerning the "bilateral carpal tunnel syndrome" issue, to be paid by the insurer.

KENNETH C. SNOW, Claimant
John C. O'Brien, Claimant's Attorney
Meyers & Terrall, Defense Attorneys

WCB 86-01477
August 26, 1987
Order on Review

Reviewed by the Board en banc.

The self-insured employer requests review of Referee Menashe's order that set aside its denial of claimant's industrial injury claim relating to an acute upper respiratory infection. The issue is compensability. The claimant has filed no brief on Board review.

Claimant filed a claim in November 1985 contending that exposure to cold in the course of his employment as a truck driver had caused him to come down with an acute upper respiratory infection (i.e. a cold). Claimant treated with Dr. Day, a family practitioner, and missed a couple of weeks of work.

The circumstances surrounding the allegedly injurious exposure occurred as claimant was driving a truck over a mountain pass and the engine failed. It was cold and there was about a foot of snow on the ground. Claimant had to walk a short distance to a house to call his employer and then had to repair his truck. Claimant wore a jacket, hat and gloves, but indicated that these did not keep him warm. It took an hour or so to repair the truck.

In repairing the truck, claimant had to reroute a portion of his electrical system and when he finally did get back on the road, his heater was inoperable. He felt cold until he got to his destination about three hours later. Claimant unloaded his truck and then went to a motel where he went to bed and slept eight hours. The next morning, claimant noticed that his throat was sore. He returned to his truck and drove it back to his original starting point. He was uncertain, but thought that he probably put his chains on and took them off at least once during this return trip. Within the next few days, claimant experienced achiness, congestion, coughing and other symptoms of a cold and sought medical treatment.

The only medical evidence in the file is an 827 form signed by Dr. Day with the box labeled "Is condition work related?" checked "Yes." The Referee concluded that claimant's claim was one for industrial injury rather than occupational disease because the exposure to cold which allegedly caused claimant's condition had occurred in a discrete time period of a day or two. See Valtinson v. SAIF, 56 Or App 184, 187-88 (1982). He considered Dr. Day's 827 form sufficient to carry claimant's burden of proof on the issue of medical causation and emphasized that the employer had not developed any contrary medical evidence.

On Board review, the employer argues that the Referee erred in concluding that claimant's claim was for an industrial injury rather than an occupational disease. It also contends that the check mark on the 827 form is not sufficient proof of medical causation.

Assuming, without deciding, that the Referee correctly characterized claimant's claim as one for industrial injury, we conclude that the evidence in this case does not establish that claimant's exposure to cold was a material contributing factor in the development of the claimed condition. Dr. Day's check mark provides no explanation for his conclusion. We cannot assume that the basis of that conclusion satisfies the legal definition of

medical causation. See Loehr v. Liberty Northwest Ins. Corp., 80 Or App 264 (1986). Claimant testified to a temporal relationship between his exposure to cold and the onset of his symptoms, but freely conceded that he could not prove that his symptoms were related to that exposure, saying, "I'm not a doctor." As for the employer's failure to develop contrary medical evidence, it is claimant's burden to prove the compensability of his claim, not the employer's to disprove it. Gerald W. Hannah, 39 Van Natta 109, 112 (1987). We conclude that claimant has failed to carry that burden in this case.

ORDER

The Referee's order dated October 16, 1986 is reversed.

Board Member Lewis, dissenting:

Because I agree with the Referee that claimant has met his burden of proof, I respectfully dissent from the majority opinion.

The evidence submitted to the Referee came primarily from two sources: (1) claimant's testimony regarding the events leading to the development of his upper respiratory infection; and (2) the treating physician's "check-the-box" report, which indicated that the infection was work-related. Claimant was the only witness to testify. The Referee did not make a specific credibility finding with regard to the witness. I infer from his compensability finding, however, that the Referee found claimant credible. The only medical evidence in this record also supports claimant's claim.

The majority acknowledges that all of the evidence favors claimant. It finds, however, that the evidence is not persuasive. It must be remembered that claimant need only prove his claim by a preponderance of the evidence, i.e., evidence demonstrating that it is "more likely than not" that the claim is compensable. Hutcheson v. Weyerhaueser Co., 288 Or 51 (1979). In the present case, claimant described his industrial exposure to his treating physician and the doctor indicated that the exposure caused claimant's respiratory condition. Claimant gave the same description to the Referee. Neither claimant's testimony nor the report of his doctor were rebutted by the employer. In my view, therefore, it is "more likely than not" on this record that claimant's condition developed as he alleges.

For the above-stated reasons, I respectfully dissent.

CARL J. WARREN, Claimant
Mark Kramer, Claimant's Attorney
Roberts, et al., Defense Attorneys

WCB 85-03389
August 26, 1987
Order on Review

Reviewed by Board Members McMurdo and Ferris.

The self-insured employer requests review of those portions of Referee Lipton's order that set aside its denials of claimant's aggravation and medical services claims relating to his low back condition on the ground that his condition was compensable as a new occupational disease. The employer contends that the Referee was without jurisdiction to decide the occupational disease claim because the claim was first asserted during the hearing. In the alternative, it requests that the

Board remand the case for further development on the issue. Claimant contends in his brief that even if the Board concludes that the occupational disease claim was improperly decided by the Referee, he has carried his burden of proving his aggravation and medical services claims. The issues are jurisdiction, remand, compensability, aggravation, medical services and extent of disability.

Claimant injured his low back in January 1983 in the course of his employment as a security officer for a hospital, when he slipped and fell on his back while descending a flight of stairs. The injury was diagnosed as a lumbar strain and was treated conservatively. Claimant returned to work about three weeks after the accident. The claim was closed by the employer by Notice of Claim Closure in March 1983. Claimant continued to complain of low back pain after claim closure and was off work again for about five weeks during June and July 1984. A Determination Order issued in September 1984, granting claimant additional temporary disability compensation, but no award of permanent disability. Claimant appealed the Determination Order.

Claimant returned to his job and worked for the next year with periodic treatments for his low back. In October 1985, he experienced a more marked increase in low back pain, again left work and treated with Dr. Noall, an orthopedic surgeon.

An independent medical examination was performed by Dr. Langston, an orthopedist, in December 1985. He noted subjective complaints of low back and right buttock pain, but found nothing objective to support these complaints. He concluded that claimant was medically stationary, was without permanent impairment and could return to work without restrictions. A couple of weeks later, the employer issued a denial which stated in pertinent part:

> "[W]e must notify you that we will be unable to accept your aggravation claim for your back condition. Our denial is based on the fact it does not appear your condition was worsened by or arose out of and in the scope of your employment, either by accident or occupational disease, within the meaning of the Oregon Workers' Compensation Law."

Claimant requested a hearing on the denial and marked compensability, aggravation and medical services, among other issues, in his application to schedule a hearing.

Claimant continued to treat with Dr. Noall and returned to work in January 1986. In March 1986, Dr. Noall reported that he did not think that claimant's back condition was causally related to his January 1983 injury. Instead, his diagnosis was degenerative disc disease. He was unable to state whether claimant's injury had affected this condition. He made no comment regarding whether claimant's work activity for the employer had worsened the condition.

About the same time, Dr. Satyanarayan, a specialist in physical medicine who had been involved in claimant's treatment, stated that claimant's condition represented an aggravation of his 1983 injury. He noted that x-rays taken in October 1985 showed no evidence of degenerative disc disease as diagnosed by Dr. Noall.

A few weeks later, claimant began treating with Dr. Green, a chiropractor. She related claimant's need for treatment to his 1983 injury. The employer issued a medical services denial in July 1986. At the hearing, Dr. Green testified that claimant's original injury had caused a spasm of one of the muscles attached to the spine and that this had never been properly treated, thus resulting in a cycle of increased lumbar lordosis, facet joint dysfunction, muscle spasm and pain.

Dr. Degge, an orthopedist, also testified at the hearing. He diagnosed claimant's original injury as a minor strain. He concluded that this injury had resolved within a short time and attributed claimant's current symptoms to arthritic changes in the facet joints due to excessive congenital or developmental lumbar lordosis and the wear and tear of everyday activities. He supported his conclusions by pointing out the arthritic changes in x-rays. When questioned on cross-examination regarding whether claimant's work activity as a security guard had worsened this arthritis, Dr. Degge stated, "I think his condition is going to deteriorate no matter what he does."

The Referee accepted Dr. Degge's conclusions regarding the nature of claimant's original injury and his current condition. Based upon Dr. Degge's testimony regarding the ongoing deterioration of claimant's condition, however, he ruled that claimant had established a compensable occupational disease by proving a pathological worsening of his preexisting condition.

On Board review, the employer argues that the Referee improperly decided the case on an occupational disease theory or, in the alternative, that the Board should remand the case for further development. In any event, the employer contends that the evidence was insufficient to support the Referee's finding of compensability.

We conclude that the Referee properly reached the occupational disease issue. It was one of the grounds for the employer's denial and claimant raised compensability as an issue in his application to schedule. On the merits, however, we agree with the employer that the evidence was not sufficient to support the Referee's compensability finding. Dr. Degge indicated that the arthritis associated with claimant's excessive lumbar lordosis was gradually worsening with daily living whether claimant was at work or elsewhere. Claimant had the burden of proving that his work activity was the major contributing cause of the worsening. Dethlefs v. Hyster Co., 295 Or 298, 309-10 (1983); Weller v. Union Carbide Corp., 288 Or 27, 35 (1979). Dr. Degge's testimony suggests that claimant's work activity was partially responsible for the worsening, but also indicates that it was not the major contributing cause. Claimant developed no other evidence which satisfies this requirement. His occupational disease claim, therefore, must fail.

As for the aggravation and medical services denials, they should be upheld if Dr. Degge was correct and claimant's current condition is due to the arthritis secondary to excessive congenital or developmental lumbar lordosis. We agree with the Referee that Dr. Degge's conclusions are the most reasonable of those developed in the record and thus uphold the insurer's denials.

Claimant also presented extent of disability as an alternative issue. In light of his conclusion that claimant had sustained a new occupational disease, the Referee affirmed the Determination Order since it related to claimant's resolved 1983 industrial injury. In light of our acceptance of Dr. Degge's conclusions, we find that claimant has failed to establish any permanent disability as a result of his 1983 industrial accident. We affirm the Referee's order on the extent issue for this reason.

ORDER

The Referee's order dated September 24, 1986, as republished by the order dated October 20, 1986, is affirmed in part and reversed in part. That portion of the order that affirmed the Determination Order dated September 26, 1984 is affirmed. The remainder of the order is reversed. The self-insured employer's aggravation denial dated December 27, 1985 and medical services denial dated July 2, 1986 are reinstated and upheld.

CHARLES R. LIES, Claimant
Philip H. Garrow, Claimant's Attorney
Alan Ludwick (SAIF), Defense Attorney

WCB 86-10833
August 27, 1987
Amended Interim Order of Remand

It has come to the Board's attention that our August 17, 1987 Interim Order of Remand inaccurately states that claimant had requested Board review. In actuality, the SAIF Corporation was the party requesting review.

Accordingly, our prior order is amended to reflect the aforementioned clarification. Otherwise, we adhere to and republish our August 17, 1987 interim order in its entirety.

IT IS SO ORDERED.

ADELBERT P. SHEPPARD, Claimant
Pozzi, et al., Claimant's Attorneys
Schwabe, et al., Defense Attorneys
Roberts, et al., Defense Attorneys
Lindsay, et al., Defense Attorneys

WCB 85-01687, 85-01769 & 85-01770
August 27, 1987
Order on Review (Remanding)

Reviewed by Board Members McMurdo and Ferris.

Claimant requests review of Referee Leahy's order that dismissed his request for a hearing. The issue is whether the insurer's motion to dismiss should have been granted without allowing claimant an opportunity to respond.

In November 1984, claimant filed an occupational disease claim for bilateral hearing loss. Kaiser Cement (originally insured by The Farmers Insurance Group and, later, by CDS of Oregon) and Riedel International, Inc., insured by American International Adjustment Company (AIAC), each denied the claim. In February 1985, claimant timely requested a hearing. A hearing was scheduled for April 28, 1986.

On April 4, 1986, AIAC requested an order to allow it to speak ex parte with Dr. Milligan, claimant's treating physician. In so doing, AIAC stated:

"Please consider this a motion for an order to allow us to speak with the doctor

without the presence of [claimant's attorney] or the necessity of arranging a deposition. Furthermore, . . . we also request a postponement of the hearing until we have had an opportunity to talk with Dr. Milligan.

". . . This request is based on the Board's Order on Review in the case of Allen W. Hays [sic] . . . ."

A few days later, claimant responded to AIAC's motion. Claimant argued that he had a statutory right to privileged communication with Dr. Milligan pursuant to ORS 40.232. He had no objection, however, to a deposition of Milligan.

On April 29, 1986, the Referee ruled:

"1. Defendant is allowed unrestricted access to claimant's treating doctor or doctors.

"2. If claimant does not comply within 90 days of the date of this Order defendant may move for dismissal. OAR 438-06-085. Allen W. Hays [sic], 37 Van Natta 1179 . . . ."

Claimant's attorney was out-of-state from July 27, 1986 through August 11, 1986. On July 30, 1986, the legal secretary for AIAC's attorney contacted Dr. Milligan, but he apparently refused to talk without the presence of claimant's attorney. On August 5, 1986, AIAC requested dismissal of claimant's request for hearing. On August 11, 1986, the Referee dismissed the hearing request. The dismissal order issued before any response from claimant had been received.

We find that the dismissal order should not have issued until ten days after AIAC's motion. OAR 436-06-045 provides:

"Pre or post hearing motions shall be in writing and copies served on all parties. Ten days after service shall be allowed for written response to a motion." (Emphasis added).

The mandatory language of OAR 436-06-045 requires that a party be allowed a ten-day period to file a written response to prehearing motions. Here, AIAC's written dismissal request occurred prior to a hearing on claimant's denied claim. Consequently, we find that claimant had ten days to file a written response to AIAC's motion. Yet, the Referee dismissed claimant's case only six days after AIAC served its motion and before any response had been received from claimant. Accordingly, we conclude that this matter must be remanded to allow claimant ten days to respond to AIAC's motion. Once the response is received, the Referee may then consider AIAC's motion to dismiss the hearing request.

Lastly, both claimant and AIAC have requested supplementation of the record on review. Inasmuch as the documents at issue are presently part of the record, the requests are denied.

ORDER

The Referee's order dated August 11, 1986, is vacated and this matter is remanded to Referee Leahy for further proceedings consistent with this order.

BERENICE C. GLOVER, Claimant
Welch, et al., Claimant's Attorneys
Raymond Smitke (SAIF), Defense Attorney

Own Motion 87-0119M
August 28, 1987
Own Motion Order on Reconsideration

The Board issued an Own Motion Order on March 25, 1987 whereby the request for own motion relief was denied as it was found claimant's compensable condition had not worsened and claimant had not performed gainful employment for a significant period of time. Claimant has requested that the Board reconsider its order, based in part on the findings of Referee Fink that claimant's condition was not a new injury and that her condition had worsened. SAIF opposes the relief claimant seeks, contending there is no evidence of a worsening of the compensable condition.

The new petition indicates that the Board did not have a complete record when its order issued in March 1987. At that time, we had no evidence of her work activities in January 1987. Our ruling under Cutright v. Weyerhaeuser Company, 299 Or 290 (1985) was improper based on the evidence we now have.

We also ruled that the "medical evidence fails to substantiate a worsening of claimant's compensable condition sufficient to justify claim reopening under ORS 656.278." Nothing new has been submitted to refute this ruling. We find the Referee's statement that claimant's condition worsened is not inconsistent with our ruling. The Referee also stated that "[t]he preponderance of evidence from the medical documentation reveals an increase in symptomatology only . . . ." We find an increase in symptoms which is entirely consistent with the permanent disability award claimant has been granted. We are unwilling to reopen claimant's claim on this record.

The request for own motion relief is hereby denied.

IT IS SO ORDERED.

SNELSON McGRIFF, Claimant
Svoboda & Associates, Claimant's Attorneys
Dennis Ulsted (SAIF), Defense Attorney

WCB 85-08395
August 28, 1987
Order on Review

Reviewed by Board Members Lewis and Ferris.

Claimant requests review of that portion of Referee Quillinan's order that: (1) awarded five percent (16 degrees) unscheduled permanent disability for claimant's back condition in addition to the Determination Order's award of 15 percent (48 degrees) unscheduled disability; and (2) awarded no scheduled permanent disability for his right foot. In its brief, SAIF requests review of that portion of the order that: (1) awarded claimant five percent (7.5 degrees) scheduled permanent disability for his left wrist; and (2) declined to allow SAIF to offset unscheduled permanent disability paid pursuant to a previous Determination Order. If the request to reduce claimant's award of scheduled disability for the left wrist is granted, SAIF seeks

authorization to offset the permanent disability paid pursuant to the Referee's order. The issues are extent of scheduled and unscheduled permanent disability and offset.

Claimant is 49 years old and has a ninth grade education. He has no formal training. His work history consists of heavy labor in construction, truck driving, 15 years as an automobile mechanic and operating his own landscaping business. In 1984 claimant worked as an assistant manager of an apartment complex. His duties included remodeling apartments, landscaping and general maintenance.

In November 1984 claimant was attempting to move a cement mixer when he fell and compensably injured his back. Initially, he treated with Dr. Boyd, orthopedist, who diagnosed contusion of the low back. The pain in claimant's back persisted and in February 1985 he was referred to Dr. Englander, neurologist. Dr. Englander diagnosed lumbosacral strain and right foot clonus. In March 1985 an MRI scan was interpreted as normal. In May 1985 Dr. Englander released claimant for work with no lifting over 20 pounds or repetitive bending. Dr. Englander noted that claimant's restrictions were permanent and that he would be unable to return to heavy activities. In July 1985 a Determination Order awarded 20 percent unscheduled permanent disability.

In September 1985 Dr. Bamforth, chiropractor, stated that claimant had experienced severe worsening of his back condition. Dr. Bamforth noted, however, that if claimant continued to improve, the restrictions Dr. Englander placed on him would not be necessary. In October 1985 Dr. Englander stated that claimant had experienced an exacerbation of his lumbar facet disease with no neurological impairment and no radicular disease. Disagreeing with Dr. Bamforth, Dr. Englander stated that it was unlikely claimant would return to full activity and felt he would continue to have the same permanent limitations.

In December 1985 Dr. Bamforth reported that claimant would be unable to return to work as a dry waller. Standing and sitting were limited to 3 to 5 hours at a time. Finding no restrictions with regard to claimant's hands, Dr. Bamforth concluded that he could perform fine manipulation, pushing, pulling and grasping. Dr. Bamforth further stated that claimant could bend and climb occasionally with no crawling and should be allowed to change positions frequently. On February 28, 1986 Dr. Bamforth declared claimant medically stationary with the above restrictions. In March 1986, with the aid of vocational rehabilitation, claimant returned to work as an apartment manager.

In April 1986 a Determination Order issued, decreasing claimant's unscheduled permanent disability award to a total of 15 percent. Subsequently, claimant was terminated from his job as apartment manager. Vocational reports indicate that claimant was fired for refusing to perform requested work and being abusive to tenants. Claimant testified that while employed he had painted 18 apartments and had been asked to repair concrete and perform landscaping activities beyond his physical capabilities. Claimant stated he was terminated due to his inability to perform the requested work. At the time of hearing, claimant was a self-employed artist living in California.

We reverse that portion of the Referee's order that awarded claimant five percent scheduled permanent disability for his wrist condition.

Claimant must establish that his disability is related to his compensable injury. Here, claimant never indicated that he had sustained an injury to his wrist until the time of hearing. None of the medical reports indicate he treated for a wrist condition or reported any limitations. Further, Dr. Bamforth stated that claimant had no restrictions involving his hands. Consequently, we conclude that claimant has not established that he suffered a compensable wrist condition around which disability could be considered. SAIF is not entitled to offset the permanent disability paid for the wrist condition pursuant to the Referee's order. See ORS 656.313.

We modify that portion of the Refeee's order that awarded claimant an additional five percent unscheduled permanent disability for his low back condition.

In rating the extent of claimant's permanent disability, we consider his physical impairment, which includes his credible testimony concerning his pain, physical limitations and relevant social and vocational factors set forth in OAR 436-30-380 et. seq. We do not apply these rules as rigid mechanical calculations that are determinative of the final result. Fraijo v. Fred N. Bay News Co., 59 Or App 260 (1982). Claimant is 49 years old and has a ninth grade education. The record persuasively establishes that claimant's low back condition precludes him from all past heavy labor occupations. Consequently, we find that he is entitled to additional unscheduled permanent disability beyond the five percent unscheduled permanent disability awarded by the Referee. Accordingly, claimant is awarded an additional 10 percent permanent disability, giving him a total award of 30 percent unscheduled permanent disability.

Finally, we reverse that portion of the Referee's order that declined to allow SAIF to offset the five percent unscheduled permanent disability overpayment created by the April 1986 Determination Order.

Claimant is not obligated to repay compensation awarded by a Referee that is reduced or eliminated following a Board or Court order. ORS 656.313(2). However, here claimant's award was reduced pursuant to a Determination Order. Moreover, ORS 656.268(4) permits adjustments in compensation including the disallowance of permanent disability payments prematurely made. We have previously held that to the extent a subsequent Determination Order reduces an award of permanent disability, the reduced permanent disability is prematurely made and subject to adjustment. Debbie A. Monrean (Kahn), 38 Van Natta 97, on reconsideration, 38 Van Natta 180 (1986). Consequently, we conclude that SAIF is permitted to offset the five percent unscheduled permanent disability overpayment created by the April 1986 Determination Order.

ORDER

The Referee's order dated October 10, 1986 is reversed, affirmed and modified. That portion of the Referee's order that

awarded five percent (7.5 degrees) scheduled permanent disability for loss of use and function of claimant's left wrist is reversed. In addition to the Referee's award of five percent (16 degrees) unscheduled permanent disability for his back condition, claimant is awarded 10 percent (32 degrees) unscheduled permanent disability, for a total of 30 percent (96 degrees) unscheduled permanent disability. The SAIF Corporation is authorized to offset the five percent unscheduled permanent disability overpayment created by the April 1986 Determination Order against the award of additional unscheduled permanent disability. Claimant's attorney is allowed 25 percent of the additional compensation granted by this order. However, the total fees approved by the Referee and Board concerning this issue shall not exceed $3,000. The remainder of the order is affirmed.

JOHN D. SCHUENING, Claimant
Kenneth D. Peterson, Claimant's Attorney
Meyers & Terrall, Defense Attorney

WCB 85-00949
August 28, 1987
Order on Remand

This matter is before the Board on remand from the Court of Appeals. Schuening v. J. R. Simplot & Company, 84 Or App 622 (1987). The court has concluded that claimant's condition was not medically stationary on the date of claim closure. Consequently, this case has been remanded to the Board for "a determination of benefits payable for October 1, 1984 to April 1, 1985."

Consistent with the court's opinion, we conclude that claimant is entitled to temporary total disability compensation from October 1, 1984 to April 1, 1985. In addition, as a reasonable attorney fee, claimant's attorney is awarded 25 percent of this increased compensation. This fee is payable from claimant's temporary disability award.

IT IS SO ORDERED.

DIANE L. KORTER, Claimant
Ann Kelley, Ass't. Attorney General

WCB CV-87007
August 4, 1987
Crime Victim Order

Applicant has requested review by the Workers' Compensation Board of the Department of Justice's Findings of Fact, Conclusions and Order on Reconsideration dated May 19, 1987. By its order, the Department denied applicant's claim for compensation, filed pursuant to the Compensation of Crime Victims Act (Act). ORS 147.005 to 147.365. The Department based its denial on: (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 her request for review, applicant was advised that she was entitled to a fact finding hearing before a Special Hearings Officer. Applicant did not timely request a hearing. See OAR 438-82-025(1). We have, therefore, conducted our review based solely on the record filed by, and the written arguments received from, the Department of Justice. 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.

Applicant is the mother of a minor child. The child was the innocent victim of a criminal sexual assault on February 18, 1986. Applicant notified police authorities of the crime on February 19, 1986 and cooperated in prosecuting the assailant. Applicant signed a claim for crime victim compensation on March 11, 1987, more than one year after the crime occurred. The Department received her claim on March 24, 1987. Applicant asserts that she did not file a claim for compensation within one year because: (1) she was unaware that her daughter needed psychological assistance until more than one year after the crime occurred; and (2) she was not informed that she could file a claim for compensation until more than one year after the crime occurred.

On April 13, 1987, the Department issued its Findings of Fact, Conclusions and Order, denying applicant's claim as having been untimely filed. Applicant requested reconsideration, alleging that because of the unique circumstances surrounding the filing of her claim, the claim should be allowed. The Department issued an Order on Reconsideration on May 19, 1987, adhering to its prior order. Thereafter, applicant timely requested review by the Workers' Compensation Board.

CONCLUSIONS

ORS 147.015 provides that an applicant is entitled to compensation under the Act if, among other requirements:

> "(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 extention 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 initial six month period from the date of injury. Id. In the interest of orderly and consistent administration, however, 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 this record, we conclude that the Department's Order on Reconsideration should be affirmed. Applicant did not file her claim for compensation within the one year period allowed by rule, and there is no evidence that the failure to timely file was the result of injury-related mental or physical incapacity.

Although we affirm the Department's order, we do so with regret. It appears from the record that applicant was not informed of the potential availability of crime victim

compensation until the time for filing had expired. Thus, in a very real sense, she was precluded from pursuing compensation by circumstances beyond her control. We sympathize with applicant's dilemma. Yet, we are required to follow the applicable relevant statutes and administrative rules. Consequently, the Department's Order on Reconsideration must be affirmed.

ORDER

The Findings of Fact, Conclusions and Order on Reconsideration of the Department of Justice Crime Victim Compensation Fund dated May 19, 1987 is affirmed.

REBECCA J. FEROLIN, Claimant
Pozzi, et al., Claimant's Attorneys
Cummins, Cummins, et al., Defense Attorneys
Schwabe, et al., Defense Attorneys
SAIF Corp Legal, Defense Attorney

WCB 86-08311, 86-08310 & 86-04310
August 31, 1987
Order on Review

Reviewed by Board Members McMurdo and Ferris.

Ohio Casualty requests review of those portions of Referee St. Martin's order that: (1) set aside its "de facto" denial of claimant's claim for medical services involving the neck, mid-back and shoulder; (2) upheld Castle and Cooke's (self-insured employer) "de facto" denial of the same condition; (3) assessed a 25 percent penalty and associated attorney fees against Ohio Casualty for its alleged failure to accept or deny claimant's claim; and (4) awarded claimant a $1,750 attorney fee for services at hearing. The issues are responsibility, penalties and attorney fees. Ohio Casualty asserts that claimant's attorney should have received no fee for services at hearing. In the alternative, it argues that the fee was excessive.

We affirm the Referee's order as it pertains to penalties and attorney fees. We reverse the Referee's findings with regard to the issue of responsibility, however.

Claimant compensably injured her mid-back, shoulders and neck in October 1979 while employed by Bumble Bee Seafoods, a subsidiary of a self-insured employer, Castle and Cooke. She visited Dr. Haneline, a chiropractor, who diagnosed a cervical strain, bilateral brachial plexitis and suspected thoracic outlet syndrome. Haneline took claimant off work, ultimatety releasing her to return to the job on January 7, 1980. A subsequent Determination Order awarded a period of temporary total disability. Claimant later changed treating doctors and began visiting Dr. Sherman, a chiropractor.

Claimant testified that she experienced periodic symptomatic flare-ups up to the time she suffered a second injury in late August 1984. That injury, in which claimant experienced severe neck and right shoulder pain after pulling on some cotton batting material, occurred while claimant was employed by Ohio Casualty's insured. According to the first medical report following that injury, claimant's symptoms were similar to those she experienced after the 1979 injury. She later testified, however, that she felt new symptoms as well, primarily in the area of the shoulder blades.

Claimant filed claims with Ohio Casualty and Castle and Cooke in August 1984. Each insurer ultimately issued a denial of responsibility. The Workers' Compensation Department subsequently issued an order pursuant to ORS 656.307, designating Ohio Casualty as paying agent.

In October 1984, Dr. Sherman found claimant to be medically stationary without permanent disability. In Sherman's opinion, claimant suffered several weeks of symptoms following the second injury, and then resolved. He felt that any residuals claimant might experience thereafter would be attributable to the 1979 original injury. A December 12, 1984 Determination Order awarded temporary total disability only with regard to the August 1984 injury.

In December 1985, counsel for Ohio Casualty wrote to the Hearings Division, specifically accepting responsibility for claimant's 1984 injury and, thus, requesting that the Department's ".307" order and claimant's requests for hearing be dismissed. The insurer attempted to limit its liability to claimant's temporary flare-up of symptoms and the medical treatment provided for it from August 30 through September 24, 1984. Although the parties did not reach a formal stipulation in that regard, the Hearings Division ultimately issued an Order of Dismissal, noting Ohio Casualty's acceptance of the second injury and dismissing claimant's request for hearing in that regard. Consequently, the Department's order pursuant to ORS 656.307 was withdrawn.

Claimant continued to experience symptoms, and she submitted medical billings to the employers. The billings were never paid, however. Claimant then requested a hearing with regard to the nonpayment of medical services, and she also sought penalties and attorney fees. The hearing was held on August 14, 1986. Just prior to the hearing, claimant was examined by Dr. Gatterman, a chiropractor, who reported that claimant's current condition was most likely the result of the 1984 injury. Gatterman's opinion was partially dependent on claimant's perception that the second injury worsened her condition.

In his October 6, 1986 Opinion and Order, Referee St. Martin found the last insurer, Ohio Casualty, to be responsible. In doing so, he noted:

> " . . . I am unable to conclude that the industrial accident of August 30, 1984 plays no part in claimant's need for medical treatment or that the October 3, 1979 injury is the sole cause of claimant's need for medical treatment."

This is a successive injury case in which both of claimant's injuries have been accepted. In Industrial Indemnity Co. v. Kearns, 70 Or App 583 (1984), the claimant suffered multiple injuries during successive employments. Each injury was accepted by the appropriate insurer and benefits were paid. After the last claim was closed, the claimant sought additional treatment. Although the parties stipulated that the claimant's condition had worsened, each insurer issued a denial of responsibility. The court held that in cases involving multiple accepted injuries, followed by a worsening of the claimant's condition, a rebuttable presumption exists that the claimant's last industrial injury contributed to the worsened condition and that the insurer at that time is responsible. Id. at 587. Thus, the court held under the facts of Kearns that the burden was on the last insurer to prove that there was no causal connection between the injury it had accepted and claimant's worsened condition.

We find the general principle of Kearns to be applicable to the present case which, as we have noted, involves successive accepted injury claims. Although there has been no showing that the present claimant's condition worsened following the acceptance of the last injury, we find that the burden of proof remains with Ohio Casualty because of its previous submission to an order pursuant to ORS 656.307 and its subsequent acceptance of claimant's last claim. Kearns, supra.

Further, after reviewing the record, we find that Ohio Casualty has met its burden of proof. Dr. Sherman was claimant's long-time treating doctor. It has consistently been his opinion that claimant suffered no more than a temporary increase in symptoms following the last injury, and that claimant's current condition can be traced to the original injury. Claimant herself testified that after experiencing back pain for several weeks following the last injury, her condition essentially returned to its preinjury status. She then continued to experience symptoms linked to the original 1979 injury. Although Dr. Gatterman was of the opinion that claimant's current condition is related to the last injury, we are more persuaded by the opinion of Dr. Sherman, who had the advantage of examining claimant both before and after the last injury.

Accordingly, we find it more probable than not that claimant suffered no more than a transient symptomatic increase following the last injury, and that her current condition is related to the 1979 injury accepted by Castle and Cooke. We find, therefore, that the last insurer, Ohio Casualty, has successfully rebutted the presumption that it is responsible. The Referee's contrary holding will be reversed.

Although we affirm the Referee's award of hearing-related attorney fees, we find that no fee should be awarded for services before the Board. Claimant took the position on review that Ohio Casualty was responsible and she actively litigated that point. See Petshow v. Farm Bureau Ins. Co., 76 Or App 563 (1985), rev den 300 Or 722 (1986). In addition, there was no effective ".307" order in existence at the time of the hearing. See Robert L. Montgomery, 39 Van Natta 469 (1987). However, claimant advocated a position with regard to the responsible insurer that is contrary to our findings on review. Thus, she did not "finally prevail" against the responsible insurer. ORS 656.386: Compare SAIF v. Phipps, 85 Or App 436 (1987) and Stovall v. Sally Salmon Seafood, et. al., 84 Or App 612 (1987).

ORDER

The Referee's order dated October 6, 1986 is reversed in part and affirmed in part. That portion of the order that set aside Ohio Casualty's "de facto" denial of claimant's claim for medical services is reversed. Claimant's claim is remanded to Castle and Cooke for processing according to law. Castle and Cooke shall reimburse Ohio Casualty for claims costs and shall pay claimant's attorney fees for services at hearing. The remainder of the Referee's order is affirmed.

REFUGIO GUZMAN, Claimant
Ginsburg, et al., Claimant's Attorneys
Larry Dawson, Defense Attorney
Cummins, et al., Defense Attorneys

WCB 86-06699 & 86-09702
August 31, 1987
Order on Review

Reviewed by Board Members McMurdo and Lewis.

AMFAC, a self-insured employer, requests review of that portion of Referee Podnar's order that set aside its denial of claimant's aggravation claim for the low back and upheld Northwest Farm Bureau's denial of claimant's new injury claim in that regard. The issue is responsibility.

Claimant compensably injured his low back on November 9, 1983 while employed as a nurseryman for AMFAC. Following a period of conservative treatment, a herniated L5-S1 disk was diagnosed. Approximately one year later, Dr. Nash performed a lumbar laminectomy and diskectomy at that level. Claimant's symptoms remained, however, and in January 1985, additional testing revealed a persistent mild bulging disk and other defects at the operative level. Mild degenerative joint disease was also noted. A possible foramenal stenosis had earlier been identified by Dr. Rosenbaum. Claimant's symptoms continued into early 1986. In the interim, a May 1985 Determination Order awarded him 40 percent unscheduled disability for the effects of the original injury.

After a period off work, claimant became employed by Northwest's Farm Bureau's insured on March 4, 1986. He testified that although he did not experience a specific trauma on this second job, the work caused his symptoms to immediately return. He sought additional treatment from Dr. Nash, who attributed claimant's symptoms to the apparent forward flexed position in which claimant worked. By May 8, 1986, Dr. Nash took claimant off work because of continuing low back pain. Claimant subsequently filed claims for compensation with AMFAC and Northwest Farm Bureau. Each issued a denial of responsibility and the Workers' Compensation Department ultimately named a paying agent pursuant to ORS 656.307.

Just before it issued its denial, AMFAC sent claimant to Dr. Zivin, a neurologist. Zivin took a detailed history from claimant through an interpreter. He also reviewed claimant's prior x-rays, as well as a report of another physician who had interpreted claimant's MRI. Zivin also testified at the hearing and stated his opinion that claimant's condition had pathologically worsened as a result of his two months of employment for Northwest Farm Bureau's insured. His opinion was based on claimant's complaints of new and increased symptoms, as well as Zivin's interpretation of claimant's most recent x-rays. Zivin opined that claimant had suffered increased foramenal stenosis since films were taken in October 1985. He further indicated that claimant's condition could have progressed even without the second work exposure, but Zivin would not have expected the current degree of increased pathology without some type of catalyst. In Zivin's opinion, claimant's second period of employment provided that catalyst.

Dr. Nash, the treating surgeon, did not testify. His written reports, however, do not contradict Dr. Zivin's testimony. In fact, they tend to corroborate it. In April 1986, Nash noted that claimant had undergone "significant change" in reflexes and range of motion. He later noted that although claimant's condition could be traced to the original injury, his

current complaints were "a direct result of worsening incident to his physical efforts" on the second job.

The Referee found that claimant's second period of employment had caused no more than an aggravation of the original injury suffered at AMFAC. It appears that the Referee based his decision on two factors: (1) that claimant remained symptomatic from the time of the original injury to the time he began his second job; and (2) that there was no specific traumatic incident on that second job. Although the Referee noted Dr. Zivin's opinion that claimant's condition had worsened as a result of the second employment, he did not comment on the effect of that opinion.

In Hensel Phelps Construction Co. v. Mirich, 81 Or App 290 (1986), the court held that in order for responsibility to shift from the first to the second employer, there must be a showing that the later employment independently contributed to the causation of the claimant's disability, i.e., to a worsening of his or her underlying condition. Id. at 294. Whether or not there has been a specific trauma during the second employment is relevant to a determination of responsibility, but it is not dipositive. Id.

After reviewing this record, we find that claimant's second employment effected a pathological worsening of his underlying condition. Northwest Farm Bureau, insurer for the later employer, is therefore responsible. Dr. Zivin persuasively testified regarding the pathological changes that occurred in claimant's foramen, and he attributed at least some of the changes to the second employment. Zivin's opinion was essentially unrebutted, and the reports of the treating surgeon, Dr. Nash, lend support to his findings. The Referee's holding with regard to responsibility will be reversed.

ORDER

The Referee's order dated September 30, 1986 is reversed in part and affirmed in part. That portion of the order that set aside AMFAC's denial of claimant's aggravation claim and upheld Northwest Farm Bureau's denial of claimant's new injury claim is reversed. Claimant's claim is remanded to Northwest Farm Bureau, which shall process it according to law and reimburse AMFAC for costs incurred thus far in processing the claim. The remainder of the Referee's order is affirmed.

DONALD L. SAVAGE, Claimant
Malagon & Moore, Claimant's Attorneys
Ronald E. Rhodes, Defense Attorney

WCB 86-03679
August 31, 1987
Order on Review

Reviewed by Board Members Lewis and Ferris.

The insurer requests review of that portion of Referee Quillinan's order that granted claimant permanent total disability. In his brief, claimant requests review of those portions of the order that: (1) upheld the insurer's denial of his cervical condition; and (2) found that the claim was not prematurely closed. The issues are compensability, premature claim closure and permanent total disability.

We affirm those portions of the Referee's order that: (1) upheld the insurer's denial of claimant's cervical condition; and (2) found that the claim was not prematurely closed. We reverse the finding of permanent total disability.

Claimant worked as a stock controller for the employer for 14 years. In December 1982 he suffered a compensable right shoulder injury. In February 1983 Dr. Erkkila, orthopedist, surgically repaired a torn rotator cuff. A Determination Order issued in August 1983 awarding 15 percent unscheduled permanent disability. Claimant was released for regular work, but was unable to return to his former job since it had been eliminated. As a result, vocational rehabilitation efforts were initiated.

In July 1984, with the assistance of a wage subsidy program, claimant returned to work as an assistant manager in an auto parts store. The program was later upgraded to an Authorized Training Program to allow claimant more time in which to adjust to the work. In September 1984 a prior Referee increased claimant's award of unscheduled permanent disability to 30 percent. Subsequent vocational rehabilitation reports indicated marked improvement in claimant's adjustment to his work.

In February 1985 claimant experienced right shoulder pain and loss of motion. Dr. Butters, orthopedist, diagnosed mechanical type shoulder pain and recommended physical therapy. Claimant was released from work and his claim was reopened for aggravation of his shoulder condition. In March 1985 Dr. Erkkila suspected thoracic outlet syndrome and recommended an EMG. Dr. Mundall performed an EMG that was normal, except for mild slowing of the right ulnar nerve across the elbow suggesting a mild compressive neuropathy. Claimant's physical complaints precluded him from returning to his job as a counterman in the auto parts store.

In October 1985 a physical capacity evaluation indicated that claimant could sit or stand for eight hours per day. He could occasionally lift 10 to 25 pounds with his right arm, but could lift 26 to 50 pounds with his left arm frequently. Reaching could be performed continuously with the left arm and occasionally with the right.

Also in October 1985 claimant was examined by Dr. Rosenbaum, neurosurgeon. Dr. Rosenbaum diagnosed: (1) post partial rotator cuff tear and repair; (2) chronic cervical, thoracic strain; and (3) probable significant functional overlay. Finding claimant medically stationary, Dr. Rosenbaum recommended no additional treatment. Dr. Rosenbaum restricted claimant from using the right upper arm for repetitive lifting or lifting beyond 10 to 15 pounds. Stating that claimant could perform sedentary and light work, Dr. Rosenbaum rated the loss of function from his rotator cuff repair and cervical, thoracic strain in the mid portion of mild. Dr Rosenbaum concluded that the cervical, thoracic strain and minor underlying entrapment of the ulnar nerve were unrelated to the compensable injury. In January 1986, Drs. Butters and Crist concurred with Dr. Rosenbaum's opinion.

In November 1985 Dr. Mundall performed a myelogram to rule out a radicular basis for claimant's shoulder and scapular pain. Despite finding suggestions of herniated disc material at C6-7, Dr. Mundall concluded that claimant's problem was musculoskeletal. He had nothing more to offer other than symptomatic treatment. In March 1986 a Determination Order awarded no additional permanent disability. Vocational services continued to assist claimant in finding employment. In July 1986 the vocational counselor questioned claimant's motivation to return to work after he declined to follow up a job lead.

Following the Determination Order, surgery was recommended for claimant's cervical condition. We agree with the Referee's determination that the cervical condition is unrelated to claimant's compensable injury.

Claimant is 55 years old and has a 12th grade education. He worked in the logging industry until suffering severe injuries to both knees. In addition to logging, claimant has worked as a turkey farmer. Prior to his shoulder injury, he worked 14 years as a stock controller. He also worked as a counterman for an auto parts dealer. Vocational evidence indicates that claimant's left knee cap has been fused and the right knee cap removed. In May 1984 claimant told his vocational counselor that as a result of the knee surgery he could stand for about 20 minutes with limited movement and longer if he is able to move his legs. Claimant also reported that he could not crouch, kneel or crawl, but could walk a mile with breaks. He has no difficulty sitting. Claimant testified that the problems with his knees preclude him from carrying more than 40 pounds. In addition to his knee problems, claimant suffers from uncontrollable tremors which make it difficult for him to write. The knee injuries and tremors preexisted his compensable injury. As a result of his right shoulder injury, claimant has difficulty holding objects and has significant pain.

The Referee concluded that claimant was permanently and totally disabled. We disagree.

To establish permanent total disability, claimant must prove that he is unable to perform any work at a gainful and suitable occupation. Wilson v. Weyerhaeuser, 30 Or App 403 (1977). Permanent total disability may be established through medical evidence of physical incapacity or through the "odd lot" doctrine under which a disabled person may remain capable of performing work of some kind, but still be permanently disabled due to a combination of medical and nonmedical disabilities which effectively foreclose him from gainful employment. Welch v. Banister Pipeline, 70 Or App 699 (1984). ORS 656.206(1)(a) allows claimant's preexisting disability to be considered when determining whether he is permanently totally disabled. Disability resulting from a preexisting condition is considered as it existed at the time of the injury. John D. Kreutzer, 36 Van Natta 285, aff'd mem, 60 Or App 78 (1982). See Frank Mason, 34 Van Natta 568, aff'd mem, 60 Or App 78 (1982). Disability from a subsequent noncompensable injury is not relevant in determining the extent of the worker's permanent disability. Emmons v. SAIF, 34 Or App 603, 605 (1978).

Here, no evidence exists indicating that claimant is permanently totally disabled due solely to physical incapacity. Therefore, claimant must establish that he is totally disabled due to a combination of medical and nonmedical disabilities under the "odd lot" doctrine. In determining claimant's physical disability, we consider his shoulder condition as it existed at the time of hearing. The disability from claimant's preexisting knee conditions and tremors is considered as it existed at the time of his original injury. We have not considered the disability, if any, from the noncompensable cervical condition.

Dr. Rosenbaum concluded that claimant was capable of performing light to sedentary work. Claimant's primary attending

physicians Drs. Crist and Butters concurred with this assessment. Vocational reports have consistently indicated that claimant has transferable skills for occupations within his limitations. Consequently, we cannot conclude that claimant has established that he is permanently totally disabled.

However, we conclude that claimant's shoulder condition has worsened since the last arrangement of compensation and that he is entitled to additional unscheduled permanent disability. In rating claimant's disability we consider his credible testimony concerning pain, physical limitations and relevant social and vocational factors set forth in OAR 436-30-380 et. seq. We do not apply these rules as rigid mechanical calculations that are determinative of the final result. Fraijo v. Fred N. Bay News Co., 59 Or App 260 (1982). After de novo review of the medical and lay evidence, we conclude that claimant is entitled to an additional 10 percent unscheduled permanent disability for a total of 40 percent.

ORDER

The Referee's order dated September 29, 1986 is reversed in part and affirmed in part. In lieu of the Referee's award of permanent total disability, claimant is awarded an additional 10 percent (32 degrees) unscheduled permanent disability, concerning his right shoulder condition, for a total of 40 percent (128 degrees). As a reasonable attorney fee, claimant's attorney is allowed 25 percent of the additional compensation granted by this order. However, the total of fees allowed by the Referee and the Board shall not exceed $3,000. The remainder of the Referee's order is affirmed.

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

WCB 86-02856
August 31, 1987
Order on Review

Reviewed by Board Members McMurdo and Ferris.

Claimant requests review of those portions of Referee Brown's order that: (1) refused to consider the issue of extent of disability relating to claimant's low back because the claim had been closed by notice of claim closure and claimant had not requested review by the Evaluation Division; (2) upheld the insurer's aggravation and medical services denial; and (3) refused to consider the issue of vocational rehabilitation because claimant had not requested review by the Director. The issues are jurisdiction, aggravation, extent of disability, medical services and vocational rehabilitation.

The Board affirms those portions of the Referee's order that refused to consider the issues of extent of disability and vocational rehabilitation on jurisdictional grounds. We reverse the insurer's aggravation and medical services denial. The basis of the denial was that claimant had sustained a new injury and that claimant's condition had become the responsibility of a subsequent employer. We agree with the Referee's finding that claimant did sustain a new injury as alleged by the insurer. The insurer, however, did not join the subsequent employer as a party to this proceeding. Under the Supreme Court's recent decision in Runft v. SAIF, 303 Or 493 (1987), responsibility for claimant's condition remains with the first employer and its insurer.

ORDER

The Referee's order dated September 30, 1986 is affirmed in part and reversed in part. That portion of the order that upheld the insurer's denial dated February 20, 1986 is reversed. The denial is set aside and the claim is remanded to the insurer for processing. The remainder of the order is affirmed. Claimant's attorney is awarded $500 for services at the hearing and $200 for services on Board review on the issue of the aggravation and medical services denial, to be paid by the insurer.

WILLIAM B. WALRUFF, Claimant
Welch, Bruun & Green, Claimant's Attorneys
Schwabe, et al., Defense Attorneys

WCB 86-06010
August 31, 1987
Order on Review

Reviewed by Board Members Ferris and Lewis.

The insurer requests review of Referee Gary Peterson's order that set aside its denial of claimant's injury claim for his wrist, shoulder and back condition. The issue is compensability.

Claimant is a 27 year old general laborer. On March 30, 1986, he alleges that he was working with a co-worker, Haak, bringing up a sludge bucket from the bottom of a sump. Claimant was at the top of the hole while Haak was handing up to him a 50 pound bucket. Claimant states that Haak released the bucket before he was ready, jerking his right arm. Feeling pain in his right shoulder and neck, claimant testified that he immediately told Haak about the injury. Within 15 minutes of the injury, claimant asserted he also told co-workers Stevens and Parker. In addition, he notified his immediate supervisor, Bosh. Claimant testified that, because of the pain in his neck, he allowed co-worker Parker to attempt to physically adjust his neck.

Claimant completed work without filing a claim. Upon his arrival home, he told his girlfriend, Lang, about the incident and complained of neck pain. The following day claimant returned to work for about an hour. Claimant stated the pain became so severe that he could no longer work. Consequently, he reported the injury to his employer, Burgoyne. Burgoyne arranged for claimant to be seen by a physician. While leaving the job site, claimant observed Haak and reminded Haak not to forget about the injury.

That same day, Dr. Denker examined claimant and diagnosed neck and upper back strain. Claimant was released from regular work from March 31, 1986 to April 2, 1986. The following day, claimant contacted co-worker Stevens informing him of his release from work. Claimant stated that he has worked for Stevens, who independently owns his own business, on several occasions. On April 5, 1986, claimant worked a full day for the employer and stated that he experienced increased symptoms of pain. Due to the increased symptoms, claimant again saw Dr. Denker and obtained an extended release from work.

On April 7, 1986, claimant presented the release to Burgoyne and filed a claim. Claimant testified that Burgoyne got very upset and accused him and the other employees of being "thieves and liars." During cross-examination, claimant recalled that Burgoyne told him that he had threatened co-worker Haak with his job. As a result, claimant concluded that Haak was coerced

into denying that the incident ever took place. Yet, despite this apparent hostility, Burgoyne drove claimant and his girlfriend home. Since that time, claimant has not worked for the employer.

In June 1986 claimant treated with Dr. Jawurek for painful trapezius and neck muscles. Dr. Jawurek indicated that no permanent impairment was expected from the injury. Subsequently, claimant treated with Dr. Nelson complaining of additional pain in the low back. In August 1986 the Orthopaedic Consultants performed an examination. Diagnosing cervical strain by history, the Consultants concluded that claimant had no impairment and could return to his former occupation. The Consultants noted that claimant also complained of low back and right wrist pain. Claimant testified that he began to experience low back and right wrist pain approximately two months after the incident. He considered the wrist and low back conditions related to the original compensable injury.

Witness Lang stated that she is the girlfriend of claimant. She testified regarding claimant's complaints of neck pain following the injury. She also stated that she heard the altercation that occurred between claimant and Burgoyne. Her description of the altercation parallels claimant's version.

Witness Stevens also testified on behalf of claimant. Stevens had been fired by the employer approximately six days prior to hearing. He stated that he was unaware that claimant had been injured until the day after the incident, when claimant had come to his residence to inform him of his work release. On March 30, 1986, the day of the alleged incident, Stevens was working and recalled observing a co-worker adjusting claimant's neck. However, he was not specifically told that claimant had incurred an injury until the following day.

Stevens acknowledged that he had spoken to an investigator regarding the incident. He disagreed with the investigator's written report indicating that claimant had told him that he wanted to pull an injury with his back or neck to get time off from work. Stevens stated that in actuality claimant had only told him he was hoping to get injured to get time off from work. He acknowledged telling the investigator that claimant hated the employer and felt that he was not being treated fairly. Stevens was unaware of any employees who had been threatened by the employer for filing a workers' compensation claim. During the hearing, Stevens was shown a statement he had given the day following the incident. It stated:

> "Statement taken from Brad Stevens Monday, March 31, 1986. Brad Stevens, an operator, is also the owner of an insulation company during his off hours. Brad stated that on Monday, March 31, 1986, after [Claimant] had brought in the doctor's excuse to the office, that [Claimant] was at his residence inquiring about work. [Claimant] asked if Brad could put him to work immediately. [Claimant] told him he could not do so while [Claimant] was out on a workmen's comp claim. Brad's wife, Debbie Stevens, is a witness to this conversation. On Tuesday, April 15, 1986,

> Brad came into the office. He said [Claimant] had stopped by his residence again on Saturday, April 12, 1986, looking for work."

Stevens acknowledged that he signed the statement, but stated it was not accurate. He testified that "Immediately should be '[Claimant] asked immediately if Brad could put him to work' not 'if Brad could put him to work immediately'." He further asserted that he told the typist of the inaccuracy.

Witness Haak stated that he was working with claimant on March 30, 1986. Prior to the beginning of work, claimant complained of a stiff and sore neck. Haak had also observed a co-worker attempting to adjust claimant's neck the day prior to the incident. While working together, Haak could recall no incident in which claimant suffered an injury. Haak first heard of claimant being injured the day following the alleged injury. Acknowledging that claimant had spoken to him prior to his leaving for the doctor's appointment, Haak stated that "[H]e told me that he just told Bruce [employer Burgoyne] that he hurt his neck out at sump [sic], so if he asked me any questions, to tell him that he did or that he hurt himself out there." Haak also testified that he had been privy to a conversation in which claimant told Stevens that he was considering filing an injury claim with Burgoyne to get time off. Haak stated that he and claimant are friends, but that he refused to lie for him. He stated that Burgoyne had never threatened him.

Employer Burgoyne testified that he has previously handled work related injuries. Burgoyne stated that it is not his practice to dissuade workers from filing claims. His standard policy when a worker indicates he is injured is to get him to a doctor immediately. Following the alleged incident, Burgoyne spoke to other employes and learned of a co-worker "popping" claimant's neck the day before the injury. Haak told him that no injury had occurred while he was working with claimant. Haak further advised that claimant had asked him to tell Burgoyne that the injury had actually occurred. Based on the statements of Haak and the other employes, Burgoyne did not believe that claimant's neck condition was work related. Burgoyne admitted that at the time claimant filed the claim he was upset because he felt claimant was not telling the truth and was attempting to falsify a claim.

The Referee concluded that witness Haak was not credible. All other witnesses were found credible. Based on the credible testimony of claimant and the contemporaneous medical reports, the Referee found the claim compensable. After de novo review, we disagree.

Generally, in exercising de novo review, we defer to the Referee's determination of credibility due to the Referee's opportunity to observe the witness. Humphrey v. SAIF, 58 Or App 360 (1982). However, when credibility is based upon the substance of the witness' testimony, a reviewing body is as capable of evaluating the witness as is the Referee. Coastal Farm Supply v. Hultberg, 84 Or App 282 (1987); Davies v. Hanel Lumber Co., 676 Or App 35 (1984).

We note that had the compensability of this claim simply rested on finding either claimant or co-worker Haak credible, we

would not disturb the Referee's finding. However, numerous inconsistencies in claimant's testimony, combined with the statements of other witnesses, compels us to conclude that the claim is not compensable.

Claimant testified that he told numerous employees about the injury to his neck immediately following the incident. Yet both co-workers who did testify stated that they were unaware that claimant had suffered an injury until the following day. Further, much of the testimony provided by co-worker Stevens does not support claimant's version of a work related injury. In addition, claimant had previously told Stevens that he hoped to suffer a work-related injury in order to get time off. Moreover, Stevens stated that claimant hated the employer and felt he had been treated unfairly. The thrust of Steven's signed statement was that claimant, on two occasions, sought work from him while not medically released to do so. Claimant testified that employer Burgoyne had attempted to persuade him not to file a workers' compensation claim as it would affect his rates and break the extended period worked by his employees without an injury. Yet, this statement is directly contradicted by both Burgoyne and Stevens. Stevens stated that he was unaware of the employer ever trying to persuade an employe not to file a claim.

Claimant's testimony is not only contradicted by Stevens, but also by employer Burgoyne. Claimant remembered under cross-examination that Burgoyne admitted to him that he had threatened to fire Haak after speaking to him about this incident. Claimant stated that this threat was the reason Haak had testified that no injury had occurred. Burgoyne stated only that he had spoken to Haak about the incident and that Haak was upset because "[Claimant] had asked him to lie, that he wasn't comfortable with that." Both the testimony of Haak and the employer dispute claimant's testimony regarding threats to Haak's employment. Not only does the lack of a threat contradict claimant, but it also undermines the motive for Haak to lie under oath. Further, Haak's unrefuted testimony was that he considered himself a friend of claimant.

We recognize that given the Referee's credibility findings, none of the inconsistencies and contradictions alone are probably sufficient to dispute claimant's version of events. However, taken as a whole, we conclude that numerous inconsistencies and contradictions in claimant's testimony, combined with the testimony of other witnesses, presents a version of events we cannot accept. Consequently, we conclude that claimant has failed to establish that he suffered a compensable injury.

ORDER

The Referee's order dated September 22, 1986 is reversed.

SHARON K. ACKERMAN, Claimant
Brian Whitehead, Claimant's Attorney
Liberty Northwest, Defense Attorney

Own Motion 87-0420M
September 3, 1987
Own Motion Determination Rescinded

On August 6, 1987, we issued an Own Motion Determination closing claimant's November 19, 1979 back injury claim. Asserting that we lack jurisdiction, claimant asks for rescission of our prior order. We agree and rescind our order.

Claimant's injury claim for a left sacroiliac strain was initially deferred as nondisabling. Although she apparently missed no time from work as a result of the injury, the claim was ultimately accepted as a disabling injury. There is no indication that the claim was closed either administratively or through the Evaluation Division. See ORS 656.268(2), (3).

In late 1984 or early 1985, claimant contended that her compensable condition had worsened. She subsequently requested a hearing, raising as an issue whether the claim should be reopened under ORS 656.273. However, before the issue could be addressed, the parties entered into a March 4, 1987 stipulation. Among other concessions, the insurer agreed to reopen claimant's claim under ORS 656.273 and process it through closure pursuant to ORS 656.268.

Once claimant's condition became medically stationary, the insurer submitted the claim to the Evaluation Division for closure. In view of claimant's injury date, the claim was referred to the Board for "Own Motion" closure. Our order then issued, closing the claim.

Claimant objects to our order, arguing that the parties' stipulation forecloses the Board from jurisdiction over this matter. We express no opinion on the effect of the parties' agreement that claim closure was to be under ORS 656.268 rather than ORS 656.278. See Debra L. Wilson, 37 Van Natta 1513 (1985). However, we do concur with claimant's general contention that jurisdiction lies with the Evaluation Division.

At the time of claimant's compensable 1979 injury, no statute required closure of a claim for a nondisabling injury. ORS 656.268(3), which requires carrier closure of a nondisabling claim, became effective on January 1, 1980. Or Laws 1979, ch 839 § 4(3) and 33; Webb v. SAIF, 83 Or App 386 (1987). However, as with their current versions, the 1979 version of ORS 656.268(2) and (3) provided that disabling claims without permanent disability could be closed either through a notice of closure or by means of a Determination Order.

In the present situation, there is some question as to whether claimant's initial injury was, in fact, disabling. Yet, the claim's acceptance as disabling forecloses any further consideration of the issue. Therefore, because the claim was classified as a disabling injury, closure was required either administratively or through the Evaluation Division. See ORS 656.268(2) and (3). Inasmuch as the record fails to establish that claimant's 1979 disabling injury claim has ever been closed, we conclude that we lack jurisdiction to consider this matter under ORS 656.278.

Accordingly, we rescind our prior determination and

remand this matter to the Evaluation Division for claim closure pursuant to ORS 656.268.

IT IS SO ORDERED.

PATRICIA G. FLORY, Claimant
Pitcher & Wright, Claimant's Attorneys
Acker, et al., Defense Attorneys

WCB 86-04802
September 3, 1987
Order Denying Motion to Dismiss

The insurer has moved the Board for an order dismissing claimant's request for review on the ground that a copy of the request was not served upon all the parties within the time provided by law. The motion is denied.

The Referee's order issued April 23, 1987. The order indicated that copies had been mailed to claimant, her attorney, the employer, its insurer, and the insurer's "in-house" counsel. The order neither listed the name nor the address for the insurer's "hearing" counsel. Claimant's request for review was timely mailed to the Board on May 21, 1987. A certificate of mailing, submitted with the request, indicated that a copy of the request had been mailed to the employer, its insurer, and the insurer's "in-house" counsel. The certificate of mailing did not indicate that a copy of the request had been mailed to the insurer's "hearing" counsel. On May 27, 1987, the Board acknowledged the request for review. Also on this date, the insurer's "hearing" counsel contacted the Board and received notice of the request for review.

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). The definition of "party" does not include attorneys. 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); OAR 438-05-040(4); 438-11-005(2). Furthermore, accompanying the request was claimant's certification that copies had been mailed to all "parties" to the proceeding, including the insurer's "in-house" counsel. See ORS 656.005(19). Neither the employer, its insurer, nor the insurer's "in-house" counsel dispute this representation. Inasmuch as claimant timely mailed a copy of her request for Board review to all "parties" to the proceeding, we conclude that we have jurisdiction to consider her request. See ORS 656.295(2); Argonaut Insurance Co. v. King, supra.

Accordingly, the insurer's motion to dismiss is denied.

IT IS SO ORDERED.

CHARLOTTE HAUG, Claimant
Pozzi, et al., Claimant's Attorneys
Annala, et al., Defense Attorneys

WCB 85-08109
September 3, 1987
Order on Review

Reviewed by Board Members McMurdo and Lewis.

Claimant requests review of those portions of Referee Leahy's order that: (1) found that claimant was not permanently and totally disabled; (2) denied her request for penalties and attorney fees for the self-insured employer's alleged unreasonable refusal to pay "interim" compensation; and (3) allowed the employer an offset in the amount of $352.72. Although the employer has not formally cross-requested review, it asks that we reduce the Referee's award of 20 percent (30 degrees) scheduled permanent partial disability for the right leg. The issues are whether claimant is permanently totally disabled, extent of scheduled disability and penalties and attorney fees.

We affirm that portion of the Referee's order that refused to award penalties and attorney fees. We find, however, that claimant is permanently and totally disabled. We, therefore, modify the Referee's disability award.

Claimant is a former fruit company laborer who sustained her first compensable injury in early 1978. She fell approximately ten feet off a platform and landed on her upper back, thereby sustaining a neck injury and concussion. After a slow recovery, she returned to work. A January 1981 Determination Order awarded 10 percent (32 degrees) unscheduled permanent partial disability for the neck.

Claimant apparently did not seek medical treatment again until January 16, 1984, at which time she received medication for an undisclosed purpose. On June 13, 1984, she reported complaints of right leg parasthesia and knee pain. A few days later, she was seen for a profound right foot drop. Still later in June, claimant complained of pain and numbness in both legs. On June 21, 1984, Dr. Wilson, a neurologist, diagnosed bilateral peroneal neuropathy, probably related to work. Wilson later opined that claimant could not return to her regular work.

In October 1984, claimant underwent an exploration of the right peroneal nerve. A cyst was found at that site and after it was removed, claimant experienced short-term relief. A month later, vocational services were instituted with the goal of returning claimant to her prior place of employment in a modified job. Her vocational counselor found her a pleasant, cooperative woman who had "obviously been a busy, active person."

Dr. Staver noted in April 1985 that claimant would greatly benefit by losing approximately 50 pounds. Although Staver did not prescribe a weight reduction program, it was later noted that claimant had made an unsuccessful effort to reduce. The lack of success was partly attributed to claimant's inability to exercise because of knee pain.

On June 1, 1985, Dr. Swartz reported that claimant's preexisting degenerative knee arthritis had been "significantly aggravated by periods of forced inactivity and now by her abnormal gait attributable to the residuals of her peroneal nerve palsy." He found, however, that claimant might be capable of sedentary work.

In August 1985, claimant's employer notified her that it had no jobs within her physical restrictions. Vocational services were then terminated, and at the time of the hearing, claimant had received no retraining for lighter work.

In March 1986, claimant visited Dr. MacMillan, a psychiatrist, for depression and anxiety. She complained of symptoms dating to November 1985, when it appeared that claimant would not be returned to work. MacMillan diagnosed a major depression related to the residuals of claimant's injuries. In his opinion, claimant was probably precluded by her combined physical and mental disabilities from returning to work.

Claimant was 53 years old at the time of the hearing. She completed the sixth grade and part of the seventh. Her reading has been tested at approximately the sixth grade level. Her prior employments, including lumber mill and kitchen work, have been heavy. She is restricted from repetitive bending, stooping, lifting and carrying and is unable to remain on her feet for more than 20 minutes at a time. Claimant testified that she might be able to do a sit-down job, but as of the time of the hearing, no jobs had been identified and no retraining had been effected.

The Referee refused to award claimant permanent total disability, essentially for three reasons: (1) that claimant's arthritis condition could not be considered in rating her current extent of disability; (2) that claimant had failed to meet the "seek-work" requirement set forth in ORS 656.206(3); and (3) that claimant had failed to mitigate her disability by losing weight.

We disagree with the Referee's findings. With regard to claimant's arthritis condition, it is true that if the condition had not been effected by the compensable peroneal nerve problem, it could not be considered in rating claimant's disability. See Bob G. O'Neal, 37 Van Natta 255, aff'd mem 77 Or App 568 (1985). There is persuasive medical evidence, however, that claimant's arthritis condition was "significantly aggravated" by her compensable peroneal nerve palsy. The arthritis condition is, therefore, among the disabilities to be considered in rating claimant's disability.

We also disagree with the Referee's findings with regard to motivation. While claimant has not searched for work in the conventional sense, she has fully cooperated with all efforts to reemploy her. Her vocational file is replete with comments as to her superior motivation, and claimant has repeatedly stated her desire to return to work. Her pre-injury work record was commendable and it appears to us that claimant would be working now but for the effects of her injuries.

Finally, we disagree with the Referee's analysis regarding claimant's failure to lose weight. The Referee cited Nelson v. EBI Companies, 296 Or 246 (1984), for the proposition that a claimant has a duty to mitigate disability by losing weight, and that a failure to do so may result in the reduction of a permanent disability award. Nelson, however, is distinguishable from the present facts. In Nelson, the claimant was prescribed a weight loss program but refused to follow it. The Court found the claimant's lack of effort significant as it reduced her award. By contrast, the present claimant was not specifically prescribed a weight loss program. Further, there is evidence that she did, in

fact, attempt to lose weight, but was unable to do so partly because of her injuries. See Christensen v. Argonaut Ins. Co., 72 Or App 110 (1985). We believe that it is the effort to lose weight, rather than the success or failure to do so, that is important in determining a claimant's motivation.

It is claimant's burden to prove that she is permanently totally disabled. ORS 656.206(3). She must prove that as a result of her current and ratable preexisting disabilities, she is presently incapacitated from regularly performing work at a gainful and suitable occupation. Wilson v. Weyerhaeuser Co., 30 Or App 403 (1977). Our review of this record persuades us that claimant has met her burden of proof. While she is not totally disabled from a physical standpoint alone, see Wilson v. Weyerhaeuser Co., supra, she has substantial physical disability. In addition, claimant's age, lack of education, unsophisticated work history and lack of retraining combine with that disability to make it more probable than not that she is not regularly employable. Claimant will be awarded compensation for permanent total disability, effective as of July 8, 1986, the date of the hearing.

The employer is allowed to offset the amount of permanent partial disability already paid pursuant to the Referee's order, as prepayment of claimant's permanent total disability award. Pacific Motor Trucking Co. v. Yeager, 64 Or app 28 (1983); Donald W. Wilkinson, 37 Van Natta 938 (1985).

With regard to the offset issue, we reverse. The Referee allowed the employer an offset of $352.72 in his order. As claimant correctly points out, however, the employer specifically waived the offset issue at hearing. The offset should not have been allowed.

ORDER

The Referee's order dated August 5, 1986 is modified in part, reversed in part and affirmed in part. That portion of the order that denied claimant's request for an award of permanent total disability is modified. In lieu of the Referee's award of 20 percent (30 degrees) scheduled right leg disability, claimant is awarded permanent total disability, effective July 8, 1986. That portion of the order that allowed the employer an offset of $352.72 is reversed. The remainder of the Referee's order is affirmed. Claimant's attorney is awarded 25 percent of the increased compensation created by this order. However, the total of fees allowed by the Referee and the Board shall not exceed $3,000.

JENEVIEVE F. McCLAURIN, Claimant
John C. O'Brien, Jr., Claimant's Attorney
SAIF Corp Legal, Defense Attorney

Own Motion 86-0395M
September 3, 1987
Second Own Motion Determination on Reconsideration

On July 21, 1986, we issued an Own Motion Determination, closing claimant's February 27, 1980 injury claim. On March 5, 1987, following claimant's request for reconsideration, we affirmed and republished our prior order. Contending that the Board lacks jurisdiction, claimant has again requested that we reconsider our previous orders. We disagree.

Claimant's aggravation rights expired in July 1985. She

is presently asserting that a June 1985 medical report, submitted to the SAIF Corporation prior to the expiration of her aggravation rights, constitutes an aggravation claim. Arguing that her claim should have been treated as a claim for aggravation, claimant contends that her claim should have been closed under ORS 656.268, not by the Board under ORS 656.278.

On first blush, claimant's contention has some appeal. However, subsequent events foreclose us from addressing this matter. To begin, the June 1985 report was processed, with no objection from claimant, as a claim for medical services. Moreover, claimant's injury claim was subsequently voluntarily reopened, again without claimant's objection, with temporary disability benefits commencing in December 1985. Inasmuch as claimant's aggravation rights had expired in July 1985, claim closure was properly effectuated under ORS 656.278.

The aforementioned circumstances prompt us to conclude that the issue of whether the June 1985 medical report constituted an aggravation claim has been effectively resolved. Consequently, we conclude that we had jurisdiction to close claimant's February 1980 injury claim.

Accordingly, claimant's request for reconsideration is granted. On reconsideration, as supplemented herein, we adhere to our former orders.

IT IS SO ORDERED.

JOSEPH K. PHILLIPS, Claimant
Michael Dye, Claimant's Attorney

Own Motion 86-0415M
September 3, 1987
Interim Own Motion Order Referring Matter for Hearing

Claimant has requested reconsideration of the Board's August 19, 1986 Own Motion Order that postponed action on his Own Motion request until a pending hearing request had been resolved. This action was taken under the assumption that claimant was contending that his current condition was either the responsibility of Jeld-Wen, Inc., a self-insured employer, under his 1978 injury claim, or the responsibility of a subsequent employer/insurer, under a 1985 injury claim. Since jurisdiction over the matter arose under ORS 656.278, the formal procedure available under ORS 656.307 was not applicable. OAR 436-60-180(3); William C. Dilworth, 38 Van Natta 1283, 1284 (1986).

After further consideration, we have determined that our initial assumption was inaccurate. Rather than a different employer/insurer, the same employer, Jeld-Wen, is responsible for both injury claims.

Asserting that claimant's current condition is not attributable to his 1985 injury claim, the employer has denied claimant's aggravation claim and is processing his medical bills under the 1978 injury claim. Claimant has requested a hearing concerning the employer's denial of his aggravation claim. Furthermore, pending the outcome of the hearing and while he remains unable to work, claimant asks that he receive temporary total disability benefits under the 1978 injury claim. Should his condition subsequently be found to be attributable to his 1985 claim, claimant suggests that necessary claims processing

adjustments can then be undertaken. Although it does not dispute its ultimate responsibility for claimant's condition under either the 1978 or 1985 claim, the employer questions his entitlement to temporary total disability.

Following our review of this matter, we are persuaded that claimant has established a medically verified inability to work resulting from a worsened condition under either his 1978 or 1985 injury claim. Consequently, we conclude that, pending the Referee's determination of this claims processing question, claimant is entitled to interim compensation benefits based on his 1978 temporary total disability rate. These benefits shall commence effective March 4, 1987, and shall continue, less time work, until claimant is released to regular work, returns to regular work, or his claim is closed pursuant to ORS 656.278.

We shall retain jurisdiction concerning claimant's request for Own Motion relief, awaiting the outcome of the forthcoming hearing in WCB Case Nos. 86-05390 and 86-10171. Yet, we temporarily refer this claims processing issue to Referee Knapp with the following instructions. In the event that the Referee finds that claimant's current condition is attributable to his 1978 injury, the Referee shall submit a recommendation to the Board concerning claimant's request for Own Motion relief. A recommendation shall also be submitted should the Referee find that claimant's condition is related to his 1985 injury. However, in addition, the Referee shall authorize the employer to offset the temporary disability benefits made payable by this order against the temporary disability compensation resulting from the Referee's order.

Following the Referee's order and recommendation, the parties should advise the Board of their respective positions concerning this matter. Upon receipt of these materials, we shall issue a final, appealable order.

IT IS SO ORDERED.

MONTE G. ROBBINS, Claimant
Kenneth D. Peterson, Claimant's Attorney
Roberts, et al., Defense Attorneys
Schwabe, et al., Defense Attorneys

WCB 85-09237 & 85-06722
September 3, 1987
Order on Review

Reviewed by Board Members Ferris and McMurdo.

EBI Companies requests review of Referee Menashe's order that set aside its denial of claimant's aggravation claim relating to his neck and low back. The issues are aggravation and extent of disability.

Claimant injured his neck and low back in November 1983 in the course of his employment as a truck driver, when the truck that he was driving rolled over. He was treated conservatively by a chiropractor, Dr. Peterson, but continued to complain of low back and neck pain and headaches. Claimant attempted to return to work on several occasions as a truck driver or clean-up worker, but left these jobs within a few weeks because of increased discomfort.

The Orthopaedic Consultants examined claimant in December 1984. They concluded that he was medically stationary

and rated his impairment at zero. They also commented that continued chiropractic treatment was counterproductive and should be discontinued. The claim was closed by Determination Order in April 1985 with no permanent disability award.

A couple of weeks after claim closure, Dr. Peterson expressed his disagreement with that portion of the Consultants' report that recommended discontinuation of chiropractic treatment. He stated that claimant continued to be symptomatic and that his treatments allowed him to continue working. He agreed that claimant was medically stationary, but did not rate his impairment.

In May 1985, Dr. Peterson reported that claimant had quit his most recent employment as an equipment clean-up worker because of increased low back pain. EBI issued an aggravation denial the following month. Claimant requested a hearing on the denial and also requested a hearing on the Determination Order closing his claim.

A new panel of the Orthopaedic Consultants examined claimant in August 1985. They found him medically stationary and rated his low back impairment as minimal. Independent Chiropractic Consultants examined claimant in November 1985. They found him medically stationary and rated his impairment at zero (although they also recommended that claimant be provided vocational services and seek less physically demanding work).

At the hearing, claimant indicated that his work on the clean-up crew had gradually worsened his neck and low back pain to the point where he had to quit working. The Referee concluded that claimant had proven an aggravation and set aside the denial.

After the Referee issued his order, the Supreme Court clarified the standard for determining a worsening under ORS 656.273 in Smith v. SAIF, 302 Or 396 (1986). Under that standard, a claimant must demonstrate a change in his condition, either pathologically or symptomatically, and entitlement to additional permanent or temporary disability. The Board has since ruled that the mere waxing and waning of symptoms is insufficient to establish a worsening under Smith. Kevin J. Geyer, 39 Van Natta 391, 394 (1987).

We conclude that claimant has not shown more than a waxing and waning of symptoms. His inability to continue working as an equipment clean-up worker was merely the last in a series of abortive attempts to return to work and did not reflect a change in his condition. See Carl L. Bohrer, 39 Van Natta 108 (1987). We, therefore, reverse that portion of the Referee's order that set aside EBI's aggravation denial.

On the alternative issue of extent of disability, we conclude that claimant has sustained impairment to his low back in the minimal range as a result of the industrial accident. In rating the extent of his unscheduled disability, we consider all of the relevant social and vocational factors set forth in OAR 436-30-380 et seq. We apply these rules as guidelines, not as restrictive mechanical formulas. See Harwell v. Argonaut Insurance Co., 296 Or 505, 510 (1984); Howerton v. SAIF, 70 Or App 99, 102 (1984).

Claimant was 21 years old at the time of the hearing. He has a tenth grade education and has spent most of his short

work life as a truck driver. Exercising our independent judgment in light of claimant's level of impairment and the relevant social and vocational factors, we conclude that an award of 16 degrees for five percent unscheduled permanent partial disability adequately and appropriately compensates claimant for the permanent loss of earning capacity due to the industrial injury.

ORDER

The Referee's order dated September 22, 1986 is affirmed in part and reversed in part. Those portions of the order that set aside EBI Companies' aggravation denial dated June 24, 1985 and awarded an associated attorney fee are reversed. EBI's denial is reinstated and upheld. The remainder of the order is affirmed. Claimant is awarded five percent (16 degrees) unscheduled permanent partial disability for his low back. In lieu of the attorney fee awarded by the Referee, claimant's attorney is awarded 25 percent of the increased compensation granted by this order, not to exceed $3,000.

ANN M. RYAN, Claimant
Coons & Cole, Claimant's Attorneys
SAIF Corp Legal, Defense Attorney

WCB 86-05502 & 85-03377
September 3, 1987
Order of Dismissal

Claimant requests review of Referee Howell's Order Approving Settlement that dismissed her pending request for hearing. Asserting that she was not aware that the denial of that condition was part of the agreement, claimant requests remand for a hearing on the merits of the denial. SAIF asks that the Board dismiss claimant's request for review as the Referee's order is not an appealable order. In addition, SAIF requests that claimant's affidavit not be considered on review as it is not part of the record.

Board review of a Referee's order is only appropriate following the conclusion of a hearing. See ORS 656.289(1); ORS 656.295; Lawrence Woods, 34 Van Natta 1671 (1982). Thus, the Referee's order approving settlement is not an appealable order. Accordingly, we grant SAIF's motion to dismiss.

IT IS SO ORDERED.

ARLENE GILKEY, Claimant
Malagon & Moore, Claimant's Attorneys
Ruth Cinniger (SAIF), Defense Attorney

WCB 86-02932
September 8, 1987
Order on Review (Remanding)

Reviewed by Board Members Lewis and Ferris.

The SAIF Corporation requests review of that portion of Referee Nichols' Order on Reconsideration that set aside its denial of claimant's medical services claim for upper back and neck surgery. In her brief, claimant requests review of that portion of the order that upheld SAIF's denial of her aggravation claim. The issues are medical services and aggravation.

In May 1979 claimant sustained an injury while attempting to move a washing machine. The diagnosis was right shoulder impingement syndrome and irritation of the lumbosacral facet joints. In November 1979 cervical spondylosis with possible radiculopathy was also diagnosed. However, this condition was not specifically related to the industrial injury. The insurer denied compensability and claimant requested a hearing. The claim was

found compensable pursuant to a May 1980 Referee's order. The order did not expressly determine which conditions had been accepted. Following the hearing, claimant continued to have problems and treated primarily for her low back and shoulder condition. No reference was made to her cervical condition. In February 1981 she underwent thoracic outlet surgery. Medical reports continued to suggest that cervical spondylosis was responsible for her continued pain, but did not specifically relate the condition to the industrial injury. In November 1981 Dr. Stevens stated that claimant had a "probable cervical strain, incidental cervical spondylosis, resolved."

In April 1982 a Determination Order issued awarding no permanent disability. Following a January 1983 hearing, a Referee awarded claimant ten percent unscheduled permanent disability for pain related to her shoulder condition. The Referee's order did not mention claimant's cervical spondylosis. The Board affirmed the Referee's order. Arlene Gilkey, 36 Van Natta 1511 (1983). Claimant continued to have problems and in August 1985 was referred to Dr. Bert, orthopedic surgeon. In September 1985 Dr. Bert diagnosed severe cervical spondylosis and recommended an interior cervical discectomy and fusion from C5 to C7. Subsequent medical reports questioned the need for surgery and in February 1986 SAIF issued a denial of the aggravation claim, stating the condition had not worsened.

At hearing, SAIF denied the request for surgery as not reasonable and necessary and, further, denied the cervical spondylosis condition as unrelated to the accepted compensable injury. Claimant's attorney claimed that he was totally unaware that SAIF intended to deny the cervical condition and thus was unprepared to present evidence concerning the compensability of claimant's spondylosis condition. The Referee concluded that the cervical condition was, by "implication", accepted by the May 1980 Referee's order. We disagree.

Nothing in the May 1980 Referee's order indicates that claimant's cervical condition was ever specifically accepted by SAIF. In Johnson V. Spectra Physics, 303 Or 49, (1987), an opinion issued subsequent to the Referee's order, the Supreme Court discussed partial denials. The Court stated that "an insurer's silence regarding one aspect of a claim is neither acceptance nor denial of that aspect of the claim." Id. 303 Or at 55. The Court approved the issuance of partial denials regarding conditions and injuries not "specifically" or "officially" accepted. Here, SAIF's partial denial of claimant's cervical spondylosis was procedurally proper. The record is devoid of any evidence that SAIF specifically accepted anything other than the low back and shoulder impingement conditions. Consequently, SAIF did not impliedly accept the cervical spondylosis condition. However, because of the timing of SAIF's denial, claimant did not have an adequate opportunity to gather evidence concerning the compensability of the cervical condition. Consequently, we find this case improperly and incompletely developed. See ORS 656.295(5).

Accordingly, we remand this case for the taking of additional evidence solely on the issue of the compensability of the cervical condition.

ORDER

The Referee's Order on Reconsideration dated October 14, 1986 is vacated and this matter is remanded to the Hearings Division for the taking of additional evidence solely on the issue of the compensability of claimant's cervical spondylosis.

VERNON J. TENBUSH, Claimant
Peter O. Hansen, Claimant's Attorney
SAIF Corp Legal, Defense Attorney

WCB 87-0309M
September 8, 1987
Own Motion Order on Reconsideration

The Board issued an Own Motion Order on June 24, 1987 whereby the request for claim reopening was denied as claimant had not performed gainful employment for approximately 4-1/2 years. The Board was particularly concerned that, even though surgery was authorized in July 1985, claimant had not had the surgery and had not returned to work. Claimant asks the Board to reconsider its order, contending that he tried unsuccessfully to get various doctors to perform the recommended surgery, finally returning to Oregon and the care of Dr. Donald T. Smith.

Claimant's contention that he tried unsuccessfully to have the surgery done out-of-state is not supported by the evidence. We conclude that the decision reached in our June 24, 1987 was proper under the circumstances. The request for own motion relief is denied.

IT IS SO ORDERED.

HAROLD D. WESTON, Claimant
Welch, et al., Claimant's Attorneys
Edward C. Olson, Defense Attorney

WCB 85-09613
September 8, 1987
Order on Review

Reviewed by Board Members Ferris and McMurdo.

Claimant requests review of Referee Lipton's order that: (1) upheld the insurer's "de facto" denial of chiropractic treatment; and (2) declined to award unscheduled permanent disability for his low back condition. The issues are medical services and extent of unscheduled permanent disability. The insurer has filed no brief on Board review.

In July 1983 claimant fell at work and injured his low back. He treated with Dr. Johansen, chiropractor, who diagnosed thoracolumbar strain with lumbosacral sprain and cervicalgia. In November 1983 the insurer denied the claim, stating that claimant's injury was not the result of his employment. Claimant timely appealed the denial.

In April 1984 claimant was examined by the Orthopaedic Consultants. The Consultants diagnosed low back strain superimposed upon claimant's preexisting Charcot-Marie-Tooth Syndrome. Claimant advised the examining physicians that he had experienced low back discomfort prior to his 1983 fall. The Consultants opined that claimant had suffered a straining injury to his back in November of 1983 disabling him until January 1984 and requiring medical treatment. The current chiropractic treatment was felt to be palliative and related to his preexisting condition rather than his industrial injury.

Subsequently, by stipulation, the insurer accepted claimant's low back claim. As part of the stipulation, the

parties resolved unpaid chiropractic bills from January 24, 1984 to July 15, 1984. The agreement did not affect claimant's right to future medical treatment. In October 1984 a Determination Order awarded no unscheduled permanent disability.

Following the stipulation, claimant treated with Dr. Johansen approximately twice a month, from October 1984 to March 1985. Claimant returned to Dr. Johansen in December 1985 and began receiving treatments one to two times per month. The insurer neither paid for these treatments nor issued a denial. At the time of the April 1986 hearing, the bills remained unpaid. In December 1985 Dr. Johansen stated that claimant had experienced recurrent low back problems since the 1983 industrial injury. Concluding that claimant's current condition was the result of his 1983 injury, Dr. Johansen noted that his condition had worsened since June 1984. Dr. Johansen opined that claimant had suffered moderate disability as a result of this injury.

Claimant is 51 years old, with a 12th grade education and two years of additional training in accounting and business. He has worked in the ministry, farming and ranching. He worked for this employer as a manager approximately 18 months prior to his injury. His preexisting condition, known as Charcot-Marie-Tooth syndrome, results in the gradual wasting of the lower extremity muscles. Claimant has limited muscle strength from the hips to his feet. As a result of this disease, he risks additional falls and is restricted to light work without repetitive lifting or bending.

Claimant has a history of prior back problems. However, he testified that his low back problem became much more severe after the 1983 injury. He never treated for his low back prior to the 1983 injury. Since the injury, claimant has constant back pain and feels that he cannot lift more than 25 pounds. At the time of hearing, claimant was unemployed. The Referee found claimant to be a reliable and credible witness.

In upholding the "de facto" denial, the Referee stated that he could not distinguish between claimant's current treatment and the treatment resolved in the previous stipulation. He further stated that he was unable to determine if claimant's current need for treatment was related to his 1983 injury or to the preexisting condition. After de novo review, we disagree.

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 recovery requires. ORS 656.245(1). 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. Johansen has treated claimant since November 1983. In his opinion, claimant has sustained permanent impairment as a result of his low back strain which requires ongoing treatment. This conclusion is supported by claimant's credible testimony regarding his recurring low back pain since the 1983 injury. The only contrary evidence is the April 1984 report of the Orthopaedic Consultants. However, the Consultants' report was two years old at the time of hearing and is not consistent with claimant's credible testimony concerning his continued low back complaints. Consequently, we are persuaded that claimant's chiropractic treatment is related to his 1983 compensable injury.

Reliance on the disputed claim settlement to find claimant's current need for services unrelated is misplaced. We consider the parties' prior resolution of chiropractic services to be irrelevant to the issue of compensability for the subsequent treatment sought by claimant.

The insurer did not issue a denial of claimant's chiropractic treatment until the time of hearing. The bills for chiropractic treatment were received by the insurer on November 20, 1984. No explanation was offered for its failure to timely deny claimant's request for medical treatment. Accordingly, claimant is entitled to a penalty and attorney fee. See Billy J. Eubanks, 35 Van Natta 131 (1983). Claimant is awarded a penalty equal to 25 percent of all medical bills outstanding at the time of hearing and a $300 attorney fee for prevailing on this issue.

Determining claimant's unscheduled permanent disability is difficult due to claimant's preexisting and unrelated Charcot-Marie-Tooth syndrome. Claimant asserts that his injury resulted in the syndrome becoming symptomatic. He therefore claims that the disability created by those symptoms should be considered when rating extent of unscheduled disability. Barrett v.D & H Drywall, 300 Or 325 (1985), recon 300 Or 553 (1986). However, we can find no persuasive evidence to support the contention that the injury resulted in the disease becoming symptomatic. Further, the record suggests that the disease is progressive and accounts for the majority of claimant's current disability. Yet, we conclude that claimant has suffered some increased disability as a result of his compensable injury.

In rating the extent of claimant's permanent disability, we consider his physical impairment, which includes his credible testimony concerning his pain, physical limitations and relevant social and vocational factors set forth in OAR 436-30-380 et. seq. We do not apply these rules as rigid mechanical calculations that are determinative of the final result. Fraijo v. Fred N. Bay News Co., 59 Or App 260 (1982). Following our de novo review of the medical and lay evidence, and considering the aforementioned guidelines, we conclude that claimant is entitled to an award of 10 percent (32 degrees) unscheduled permanent disability.

Further, we find the medical services issue to have been of average difficulty with an ordinary likelihood of success at hearing and on Board review. A reasonable attorney fee is therefore awarded.

ORDER

The Referee's order dated April 30, 1986 is reversed. The insurer's "de facto" denial of medical services is set aside. The insurer is assessed a 25 percent penalty based on the outstanding medical bills at the time of hearing and a $300 attorney fee for prevailing on this issue. Claimant is awarded 10 percent (32 degrees) unscheduled permanent disability. Claimant's attorney is awarded 25 percent of the additional compensation granted by this order, not to exceed $3,000 as a reasonable attorney's fee. For services rendered in setting aside the denial, claimant is entitled to a $600 attorney fee for services at hearing and $400 for services on Board review.

GLORIA J. KING, Claimant
Samuel A. Hall, Jr., Claimant's Attorney
Brian L. Pocock, Defense Attorney

WCB 84-11013
September 10, 1987
Order on Review

Reviewed by Board Members McMurdo and Lewis.

The self-insured employer requests review of that portion of Referee Nichols' order that set aside its denial of certain chiropractic billings. In her brief, claimant argues that she is entitled to penalties and attorney fees for the employer's allegedly: (1) unreasonable refusal to pay compensation; or (2) unreasonable delay in issuing its denial. The issues are medical services and penalties and attorney fees.

The Board affirms that portion of the Referee's order that set aside the employer's denial. We reverse that portion of the Referee's order that declined to assess penalties and attorney fees.

Penalties and attorney fees may be assessed for an employer's unreasonable delay in accepting or denying a claim. ORS 656.262(10). Here, claimant's treating chiropractor submitted a claim for medical services in December 1983. Claimant treated through February 1984. Her claim was not denied until September 1984. The employer has offered no explanation for its late denial of medical services, other than a failure to conduct its "usual investigation."

The Referee addressed only the reasonableness, not the lateness, of the employer's denial. The employer's duty to timely accept or deny a claim is clear. Its failure to do so without justification is unreasonable. Consequently, penalties and attorney fees are appropriate.

Finally, we consider the compensability issue to have been of average difficulty with an ordinary likelihood of success on Board review. Therefore, a reasonable attorney fee is awarded.

ORDER

The Referee's order is affirmed in part and reversed in part. That portion of the Referee's order that declined to assess penalties and attorney fees is reversed. As a penalty for its unreasonable delay in denying claimant's claim for medical services, the employer is assessed a penalty equal to 25 percent of the amount of those billings. For prevailing on the penalty issue, claimant's attorney is awarded a fee of $400 for services at the Hearings level and on Board review, to be paid by the self-insured employer. The remainder of the Referee's order is affirmed. For services on Board review concerning the compensability issue, claimant's attorney is awarded $500, to be paid by the self-insured employer.

LEROY A. KOCIEMBA, Claimant
Bennett, et al., Claimant's Attorneys
Gretchen Wolfe (SAIF), Defense Attorney

Own Motion 87-0162M
September 10, 1987
Own Motion Order on Reconsideration

Claimant has requested reconsideration of our July 28, 1987 Own Motion Order. Pursuant to our prior order, we declined to follow the recommendation of Referee Shebley. Thus, we concluded that claimant was not entitled to temporary total disability compensation. In the final paragraph of our order, we also noted that the issue of a possible increase in claimant's

permanent disability had been reserved at the hearing before Referee Shebley. Consequently, the parties were invited to submit additional evidence on that issue.

Upon further reflection, we find that claimant's compensable condition has worsened. Moreover, although he has not worked for many years, the record establishes that claimant was actively cooperating with vocational rehabilitation services at the time of the worsening. Under these circumstances, we conclude that he is entitled to temporary disability in the form of interim compensation.

Accordingly, claimant's 1965 injury claim shall be reopened, with temporary total disability benefits to commence effective March 4, 1987, the date of his hospitalization, and to continue, less time worked or temporary benefits already paid during this period, through May 26, 1987, the date his compensable condition became medically stationary. As a reasonable attorney's fee, claimant's attorney is awarded 25 percent of this increased compensation, not to exceed $750.

Claimant also asks that we remand the extent of permanent disability issue to Referee Shebley for resolution. Inasmuch as this issue apparently emanates from claimant's timely appeal from an October 2, 1986 Determination Order, we conclude that jurisdiction presently lies with the Hearings Division. See ORS 656.268(6). Thus, because the issue is already raised in claimant's currently pending hearing request in WCB Case No. 85-03286, it is unnecessary for us to refer this matter to Referee Shebley.

Furthermore, since the claim has been reopened within one year from the October 1986 Determination Order, claimant is entitled to claim closure by the Evaluation Division pursuant to ORS 656.268. See Carter v. SAIF, 52 Or App 1027 (1981); Coombs v. SAIF, 39 Or App 293 (1979); Roger A. Driggers, 35 Van Natta 1208 (1983); Eugene Muehlhauser, 35 Van Natta 705 (1983). Therefore, this matter is referred to the Evaluation Division for the issuance of a Determination Order. In determining claimant's entitlement to any awards of disability, the Evaluation Division is free to modify the temporary disability compensation awarded in this order.

Accordingly, claimant's request for reconsideration is granted and our July 28, 1987 order withdrawn. This Order on Reconsideration shall replace our prior order in its entirety.

IT IS SO ORDERED.

SUSAN L. SPENCER, Claimant
Doblie & Associates, Claimant's Attorneys
Davis, Bostwick, et al., Defense Attorneys

WCB 85-13913
September 10, 1987
Order on Review

Reviewed by Board Members Ferris and Lewis.

Claimant requests review of Referee Leahy's order that: (1) found that claimant had not timely appealed the insurer's denial of medical services; (2) alternatively, upheld the insurer's denial of medical services; (3) found that the compensability of certain chiropractic bills was not ripe for litigation; and (4) declined to assess penalties and attorney fees. The issues are timeliness, compensability of medical services, ripeness of the issues, penalties and attorney fees.

In early 1985, while working as a secretary, claimant began to experience neck pain with radicular complaints into her upper extremities. She treated with Dr. Matsuda, physician and surgeon. Dr. Matsuda referred claimant to Joan Ch'en for acupuncture treatment. Claimant obtained some relief from her pain symptoms. Subsequently, claimant filed an occupational disease claim for neck and upper extremity complaints. The claim was accepted as a disabling injury.

In June 1985 claimant returned to Dr. Matsuda with complaints of increased pain in her shoulders, neck, back and legs. Dr. Matsuda diagnosed diffuse muscle spasms with myositis. Claimant was taken off work. On August 16, 1985, Dr. Matsuda referred claimant for additional acupuncture treatment with Ms. Ch'en. Claimant also obtained treatment from Dr. Novick, chiropractor, who diagnosed "cervicocranial and cervicobrachial syndromes, cervical strain, dorsolumbar strain, myofascitis." On August 20, 1985, claimant submitted a change of attending physician form, indicating that Dr. Novick was her treating physician. On the form, Dr. Novick stated that he had referred claimant to "Ms. Frances Li for concurrent acupuncture treatment."

Claimant began treating with Ms. Ch'en for acupuncture treatment on September 6, 1985. On September 12, 1985 Dr. Novick referred claimant to Dr. Bergemann, Ph.D, for an exercise reconditioning program. On September 17, 1985, the insurer issued a denial of medical services. Dr. Novick's billings were denied prior to August 1, 1985 and Dr. Matsuda's billings were denied subsequent to August 2, 1985. The basis of the denial was that treatment with both physicians was concurrent care for the same condition. Ms. Ch'en's bills were also denied as concurrent care. The denial made no mention of Bergemann's physical therapy program.

On November 8, 1985, claimant requested a hearing, stating the sole issue as "[u]nreasonable resistance to payment of compensation for time loss." The request for hearing and accompanying application to schedule were received by the Board on November 12, 1985. A supplemental request for hearing and an application to schedule dated November 15, 1985 were also sent to the Board. The supplemental issue was "contesting denial letter from Aetna dated September 17, 1985." The amended request for hearing was received by the Board on November 18, 1985.

In November 1985 claimant was examined by Dr. Quan, psychiatrist. Dr. Quan concluded that claimant had no psychiatric disorder. On November 11, 1985, Dr. Novick released claimant for regular work. Shortly thereafter, claimant was examined by the Independent Chiropractic Consultants. The Consultants diagnosed cervical thoracic strain by history and felt claimant was medically stationary. Finding that claimant displayed no characteristics of impairment or disability, the Consultants agreed that claimant could return to regular work with modifications to suit her limitations.

In March 1986 Ms. Ch'en stated that claimant had been referred to her office on August 16, 1985 by Dr. Matsuda. Ms. Ch'en stated that claimant continued to improve. In April 1986 Dr. Matsuda stated that he had referred claimant to Ms. Ch'en because she had obtained good results from such treatment in early 1985. He had not seen claimant since October 1985 and was not sure how she had progressed.

In March 1986 claimant began treating with Dr. Hurd, chiropractor. In late April the insurer requested information concerning whether Dr. Hurd was claimant's attending physician. On May 15, 1986, the insurer received a change of attending physician form, indicating that Dr. Hurd was claimant's attending physician.

At the time of hearing Ms. Ch'en had outstanding bills totalling $1,555. Physical therapist Bergemann had unpaid bills totalling $370. The insurer's claim representative testified that Bergemann's bills had been in her file over 60 days. Dr. Hurd's unpaid bills dated from March 1986 and totaled $570.

The Referee concluded that the September 17, 1985 denial had not been timely appealed. We disagree.

Claimant mailed the amended request for hearing and application to schedule on November 15, 1985. The application to schedule stated that she was contesting the September 17, 1985 denial. The Board received the application to schedule on November 18, 1985. The 60th day following the denial was November 16, 1985, a Saturday. With regard to computing time periods, OAR 438-05-040(4)(c) states:

> "Time periods required or allowed by these rules shall be computed in calendar days. The first full day after the time begins to run is counted as the first day. If the last day is a Saturday, Sunday or legal holiday, the period runs until the end of the next business day."

Since the 60th day fell on a Saturday, claimant had until Monday, November 18, 1985 to appeal the denial. Consequently, claimant's appeal of the denial was timely.

We turn to the merits of the denial issue.

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). To be compensable, treatment must be reasonable and necessary. Wetzel v. Goodwin Brothers, 50 Or App 101 (1981). Claimant may have only one attending physician at a time. OAR 436-10-060(2). Further, "[p]hysical therapy, biofeedback or acupuncture shall not be reimbursed unless carried out under a written treatment plan prescribed prior to the commencement of treatment and which must be completed and signed by the attending physician within one week of the beginning of treatment." OAR 436-10-040(4)(a). The purpose of these rules is to create reasonable conditions for the payment of benefits, consistent with the policy of the statutes, enabling the system to work more effectively. Kemp v. Worker's Comp. Dept., 65 Or App 659, 669 (1983), modified, 67 Or App 270, rev den 297 Or 227 (1984).

We first consider the payment of Joan Ch'en's bills for acupuncture treatment.

Dr. Matsuda referred claimant to Ms. Ch'en on August 16, 1985. At that time, Dr. Matsuda was the attending physician. Prior to the start of her treatments with Ms. Ch'en, claimant changed her attending physician to Dr. Novick. Dr. Novick

referred claimant for acupuncture, but to a different acupuncture provider. Pursuant to OAR 436-10-040(4)(a), the insurer had no obligation to pay for acupuncture treatment until it received a treatment plan from Dr. Novick.

Here, the reports of Ms. Ch'en and Dr. Matsuda support the conclusion that acupuncture treatment was reasonable and necessary. The insurer does not contend otherwise. Consequently, the denial of acupuncture treatment shall be set aside. However, when claimant received the acupuncture treatment Dr. Novick was the treating physician. Yet, he provided no treatment plan explaining claimant's need for acupuncture treatment. Furthermore, he neither made a specific referral to Ms. Ch'en nor replied to the insurer's assertion that Ms. Ch'en's treatment was concurrent. We conclude that the insurer's denial and the withholding of payment of those bills until a determination that the treatment was justified was not unreasonable. Therefore, a penalty and attorney fee are not warranted.

We next consider the payment of Bergemann's physical therapy bills.

In September 1985 Dr. Novick referred claimant to Bergemann for an exercise reconditioning program. The claims examiner testified that she had possessed bills for the program for more than 60 days. At the time of hearing, the bills remained unpaid. Dr. Novick's referral and Bergemann's reports support the conclusion that the exercise reconditioning program was reasonable and necessary. The insurer does not contend otherwise. Accordingly, we find that the insurer's "de facto" denial of treatment should be set aside.

Following Dr. Novick's referral to Bergemann, the insurer neither requested additional information from Dr. Novick concerning the reconditioning program nor issued a denial within 60 days of receipt of Bergemann's bills. We cannot assume from the insurer's silence that the basis of its withholding payment of these bills was the treating physician's failure to provide a treatment plan. Consequently, we find the insurer's conduct unreasonable and conclude that claimant is entitled to a penalty equal to 25 percent of Bergemann's billings and a reasonable attorney fee. Billy Eubanks, 35 Van Natta 131 (1983).

We affirm the Referee's finding that Dr. Hurd's medical bills were not ripe for litigation. Claimant began treatment with Dr. Hurd in early March 1986. In late April, the insurer requested information concerning whether Dr. Hurd had become claimant's treating physician. The insurer received confirmation of this fact on May 15, 1986. Yet, at the July 7, 1986 hearing, the claims examiner stated that Dr. Hurd's bills remained unpaid.

OAR 436-10-060 concerns the choosing and changing of physicians. Pursuant to OAR 436-10-060(2), claimant may have only one attending physician at a time. Soon after claimant began treating with Dr. Hurd, the insurer relied on OAR 439-10-060(1) and requested information concerning whether Dr. Hurd was the treating physician. Accordingly, the insurer did not have an obligation to pay Dr. Hurd's medical bills until May 15, 1986, when it received verification that Dr. Hurd was the treating physician. At the time of hearing on July 7, 1986, 60 days had not elapsed from the date the change of physician form was received. The insurer has 60 days in which to pay billings for

medical services. Billy Eubanks, supra. Therefore, at the time of the hearing, payment of Dr. Hurd's bills was not an issue ripe for litigation.

ORDER

The Referee's order dated August 12, 1986 is reversed in part and affirmed in part. Those portions of the order that upheld the insurer's denials of acupuncture treatment and physical therapy are reversed. In addition, the insurer is assessed a penalty, equal to 25 percent of Bergemann's physical therapy bills, which were outstanding at the time of hearing, and $200 as a reasonable attorney fee for this issue. For services at hearing in setting aside the denials of acupuncture treatment and physical therapy, claimant is awarded $800 as a reasonable attorney fee to be paid by the insurer. For services on Board review concerning these issues, claimant is awarded $500 as a reasonable attorney fee to be paid by the insurer. The remainder of the Referee's order is affirmed.

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

Own Motion 84-0533M
September 11, 1987
Own Motion Determination on Reconsideration

The Board issued an Own Motion Determination on March 27, 1987 whereby claimant's claim was closed with no increase in permanent disability. Claimant has requested reconsideration, contending he is entitled to further permanent disability compensation. The insurer contends claimant's request should be summarily denied as it was made beyond the 30th day after issuance of the order. In the alternative, the insurer contends the May 31, 1985 date for commencing time loss benefits is incorrect and the permanent disability awards should remain unchanged.

The statement of appeal rights in our Own Motion Order of March 27, 1987 applies to petitions to the Court of Appeals. The statement does not apply to requests for reconsideration of the Board's orders issued under is own motion authority. See OAR 438-12-015. The Board denies the insurer's request that the Claimant's petition for reconsideration be dismissed.

The insurer's counsel asks on what basis the Board began time loss compensation on May 31, 1985 when claimant's surgery did not take place until July 3, 1985. The insurer's own Form 1503 indicates that it voluntarily began paying compensation on May 31, 1985. Absent compelling reasons to do otherwise, the Board will authorize the commencement of time loss benefits on the same date indicated by the insurer when a claim is voluntarily reopened.

Dr. Hoff's rating of claimant's impairment is sufficiently clear for us to rate the extent of Claimant's disability. We conclude claimant's previous 10 percent scheduled leg award should remain unchanged. However, claimant is hereby granted an increased award for 48 degrees for 15 percent unscheduled disability for injury to his left hip. This increase results in a total award of 176 degrees for 55 percent unscheduled disability. Claimant's attorney is awarded 25% of the additional compensation granted by this order, not to exceed $350 as a reasonable attorney's fee.

LEAH D'GREY, Claimant
Joel Lieberman, Claimant's Attorney
Stoel, et al., Defense Attorneys

WCB 86-02837
September 14, 1987
Order on Review

By the Board en banc.

The self-insured employer requests review of that portion of Referee Tuhy's order that set aside its "back-up" denial of claimant's industrial injury claim relating to her low back. In her brief on Board review, claimant contends that the Referee erred in refusing to assess penalties and attorney fees on the ground that the employer's denial was unreasonable. The issues are the procedural propriety of the back-up denial, compensability, penalties and attorney fees.

Claimant filed a claim for a low back injury allegedly due to an unwitnessed fall at work on October 30, 1984. The employer accepted the claim and paid benefits. After the 60-day time limit of ORS 656.262(6) had passed, the employer obtained information which led it to doubt claimant's veracity and consequently the validity of the original claim. It issued a "back-up" denial in February 1986.

At the hearing, the employer presented a great deal of evidence relating to a failure by claimant to report income from employment obtained subsequent to the acceptance of the claim. It also presented other evidence which indicated that claimant generally was dishonest and lacked veracity. The Referee noted that claimant was evasive and contradictory on the stand and found that her credibility had been seriously undermined. He nonetheless set aside the denial because he concluded that evidence of a lack of veracity did not equate with evidence of fraud, misrepresentation or other illegal activity within the meaning of Bauman v. SAIF, 295 Or 788 (1983).

We need not address the question decided by the Referee. The record contains evidence not mentioned by the Referee in his order which clearly qualifies as a misrepresentation within the meaning of Bauman and which the testimony of the employer's claims representative indicates was a material factor in causing the employer to accept the claim. That evidence was that claimant had a history of back injuries and back problems prior to the date of the alleged injury and yet expressly denied it immediately after the alleged injury. We conclude that the "back-up" denial was procedurally proper because of this misrepresentation. See Skinner v. SAIF, 66 Or App 467, 470 (1984).

Despite our conclusion that the "back-up" denial was procedurally proper, claimant has the opportunity of proving by a preponderance of the evidence that her claim was nonetheless compensable. Parker v. D.R. Johnson Lumber Co., 70 Or App 683, 687 (1984). The only evidence of the alleged accident and injury, however, was provided by claimant's testimony, which we find not credible. We, therefore, uphold the employer's "back-up" denial on the merits and also deny claimant's request for penalties and attorney fees.

ORDER

The Referee's order dated September 5, 1986 is reversed. The self-insured employer's denial dated February 20, 1986 is reinstated and upheld.

Board Member Lewis, dissenting:

Like the Referee, I do not believe the employer has carried his burden of proof, and for the reasons stated in Bauman v. SAIF, 295 Or 788 (1983), I would affirm the Referee's Opinion and Order. Therefore, I respectfully dissent.

MARY G. CHARD, Claimant
Michael B. Dye, Claimant's Attorney
Meyers & Terrall, Defense Attorneys
Cliff, Snarskis & Yager, Defense Attorneys

WCB 86-15483 & 86-17753
September 15, 1987
Order Denying Motion to Dismiss

Reviewed by Board Members McMurdo and Lewis.

Lumberman's Insurance Company and its service agency, Fred S. James & Co. (James), has moved for an order dismissing Industrial Indemnity's request for Board review on the grounds that the request was untimely filed. The motion is denied.

The Referee's order issued March 25, 1987. On April 17, 1987, James moved for reconsideration, asking that the record be reopened to afford it an opportunity to present further evidence. James further suggested that the Referee's order be abated to preserve its appeal rights. On April 20, 1987, Industrial Indemnity also moved for abatement of the Referee's order. Besides basing its motion on the preservation of appeal rights, Industrial Indemnity asserted that abatement was "necessary to ensure just resolution of the dispute." On April 23, 1987, the Referee granted Industrial Indemnity's motion.

On May 18, 1987, the Referee issued an Order on Reconsideration. Noting that the March 25, 1987 order had been abated at the request of both James and Industrial Indemnity, the Referee denied James' motion to reopen the record. In addition, the March 25, 1987 order was supplemented and republished. On May 22, 1987, Industrial Indemnity requested Board review.

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, the Referee abated the March 25, 1987 order with the express intention of considering the motions for reconsideration and preserving the parties' rights of appeal. Consequently, upon issuance of the April 23, 1987 abatement order, the March 25, 1987 order was specifically "stayed." Thereafter, the Referee's May 18, 1987 reconsideration order issued, expressly modifying and republishing the March 25, 1987 order. Inasmuch as Industrial Indemnity timely requested Board review of the Referee's Order on Reconsideration, we conclude that we have jurisdiction to consider this matter. See ORS 656.289(3); Farmers Insurance Group v. SAIF, supra; International Paper Co. v. Wright, supra.

Accordingly, the motion to dismiss is denied. James' respondent's brief shall be due within 14 days from the date hereof, with Industrial Indemnity's reply brief, if any, due within 14 days after the date of mailing of James' respondent's brief. See OAR 438-11-020; 438-11-015(2), (3).

IT IS SO ORDERED.

BILL E. FERGUSON, Claimant
Welch, et al., Claimant's Attorneys
Davis, et al., Defense Attorneys

WCB 84-00881
September 18, 1987
Order on Review

Reviewed by Board Members Lewis and McMurdo.

Claimant requests review of that portion of Referee Mulder's order that awarded 96 degrees (30 percent) unscheduled permanent partial disability for the low back in addition to the Determination Order award of 96 degrees (30 percent), bringing claimant's total award to 60 percent (192 degrees). Claimant asserts entitlement to an award of permanent total disability. He also asserts entitlement to an attorney fee for services at hearing for defending against the insurer's cross-request on the issue of extent of unscheduled disability. Although the insurer has not formally cross-requested review, it asks that we reduce claimant's unscheduled award to the level awarded by the Determination Order. The insurer also asks that we correct what it perceives to be an error in claimant's scheduled disability award. The insurer asserts that whereas the Determination Order awarded claimant scheduled disability for the left leg, and the Referee affirmed that award, the award should have been only for the left foot. The issues are extent of unscheduled disability, including permanent total disability, claimant's scheduled award and attorney fees.

We affirm the Referee's increased unscheduled award, and we agree that claimant has not proven entitlement to an award of permanent total disability. We also agree with the Referee that claimant's scheduled award for the leg should stand. Finally, we deny claimant's request for an attorney fee at hearing. Although the insurer did cross-request a hearing on the issue of extent of disability, it did not "initiate" an appeal for purposes an attorney fee award. See OAR 438-47-075; Emmett P. Curtis, 39 Van Natta 123 (1987); Richard M. Deskins, 38 Van Natta 629 (1986); Compare Travis v. Liberty Mutual Ins., 79 Or App 126 (1986). We further note that for the reasons stated in Deskins, no attorney fee shall be awarded for services on Board review.

ORDER

The Referee's order dated December 11, 1986 is affirmed.

M. RAE HANNA, Claimant
Francesconi & Cash, Claimant's Attorneys
SAIF Corp Legal, Defense Attorney

WCB 86-05727
September 18, 1987
Order on Review

Reviewed by Board Members McMurdo and Lewis.

The SAIF Corporation requests review of Referee Myers' order that granted claimant permanent total disability. On review, SAIF contends that claimant is not entitled to an award of permanent total disability. We agree and reverse.

Claimant is a former secretary at Fairview Hospital and Training Center in Salem. She was employed there in 1983, doing typing, filing and answering telephones. In late 1983, she developed severe headaches, abdominal problems and crying spells as a result of her relationship with her supervisor. She ultimately filed a claim for mental stress in December 1983. The claim was later determined to be compensable by way of a Referee's Opinion and Order.

Claimant began treating with Dr. Allen, who is apparently a general practitioner. Allen initially diagnosed migraine headaches and later noted abdominal spasms and other gastrointestinal problems. Allen became the treating physician, and claimant continued to see her as of the time of the hearing.

Claimant's emotional distress continued into early 1984, and on January 5, 1984, Dr. Mead, a psychiatrist, diagnosed a "dysthemic disorder," which he related to claimant's employment. Mead prescribed medication, but encouraged claimant to remain on the job.

When claimant's abdominal complaints continued, Dr. Allen referred claimant to Dr. Buck, a gastroenterologist. On April 22, 1984, Buck reported that claimant exhibited signs of spastic colon. He did not feel that her condition was "severe enough to totally disable her," although he deferred to Dr. Allen in that regard because of her long-term relationship with the claimant. Buck also indicated that it was his "gut reaction" that claimant was "trying to use her medical problems as an excuse not to have to work."

After receiving Buck's evaluation, Dr. Allen reported that, in her opinion, claimant's symptoms were so severe as to preclude a return to work at that time. She subsequently took claimant off work.

SAIF arranged for claimant to be examined by a psychiatrist, Dr. Quan, in August 1985. Quan diagnosed depression in "fair control," as well as a functional bowel disorder and dependent personality. Quan opined that claimant's depression was controlled to the extent that it would not preclude employment. He also felt that claimant could continue to do clerical work, so long as it was not in a stressful environment. Like Dr. Buck, Quan questioned claimant's motivation to return to work.

In early 1986, Dr. Allen referred claimant to a neurologist, Dr. Stoody. Stoody diagnosed "common migraines," and opined that there was "no reason why [claimant] should not be gainfully employed," from a neurological standpoint. An internist, Dr. Fancher, then examined claimant in March 1986 and concluded:

"Although headaches and spastic colitis are an inconvenience for [claimant], . . . I do not feel she is disabled."

Fancher agreed with Buck and Stoody that claimant could be employed in her prior occupation, so long as the environment was not stressful.

An April 17, 1986 Determination Order awarded claimant periods of temporary disability compensation and 32 degrees (10 percent) unscheduled permanent partial disability.

In February 1986, Fairview Hospital arranged for claimant to return to part-time work in a different working environment with a new supervisor. She worked only 3 1/2 hours over a period of two days, however, before leaving once again. At the time of the hearing, claimant had not returned to work.

After leaving work, claimant returned to Dr. Allen, complaining of stress-related symptoms. By September 1986, Dr. Allen opined that claimant's prospects for a return to work at that time were "poor." Vocational efforts aimed at returning claimant to her prior place of employment were terminated based on Allen's opinion.

Claimant testified that she has headaches approximately once per week, and that they may last up to three days. She also has stomach cramps caused by stressful situations. She has problems concentrating, but her crying spells have been reduced with medication. She asserts that she has actively looked for work, contacting up to ten employers per week.

Claimant testified that when she filed her stress claim in December 1983, she felt that she had been doing a good job. She was able to do the work assigned her, but she was unable to deal with her supervisor. When she returned part-time in February 1986, she worked with other employees with whom she felt comfortable, and she had no problems getting along with them. Her new supervisor showed her around her new office, accommodated her work schedule to her personal needs and explained her responsibilities. Her initial duties consisted solely of typing a list of names. Because claimant felt she wasn't learning fast enough, however, she became "totally frustrated." She visited her doctor on the next day and was again taken off work.

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., 30 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).

After reviewing this record, we find that claimant has failed to sustain her burden of proof. We find that she has proved that she cannot work in stressful environments, such as the one she left at Fairview Hospital. We also find, however, that claimant has not established that she is incapable of work at a "gainful and suitable occupation," i.e., clerical work in a nonstressful environment.

The bulk of the medical evidence suggests that claimant

is employable, albeit in nonstressful work. Dr. Buck has stated that claimant is employable from a gastrointestinal standpoint. Dr. Quan has indicated that psychiatrically, claimant can do work comparable to that she had at Fairview, but that she should not return to that specific place of employment. Dr. Stoody, the neurologist, has opined that there is "no reason why [claimant] could not be gainfully employed." Dr. Fancher, the internist, has stated that claimant's gastrointestinal symptoms will not disable her from employment in a nonstressful environment.

Only Dr. Allen indicated that claimant's prospects for a return to any work were "poor." We are uncertain, however, whether Allen intended to convey that claimant is permanently, or merely temporarily, unemployable because her opinion repeatedly states that claimant is unemployable "at this time." In any event, although Dr. Allen is the treating physician, we note that it was she who referred claimant to various specialists, and the specialists have indicated that claimant is, in fact, employable. We find the record as a whole to preponderate against a finding of permanent total disability.

We also find, however, that claimant is entitled to an increased award of unscheduled permanent partial disability. She was 50 years of age at the time of the hearing and had completed her GED. Her prior employments included work as a nurse's aide, lab technician and custodian. Other than the training she received during employment, claimant had no specific vocational preparation.

Claimant has received an award of 10 percent unscheduled disability. We find, after considering the pertinent social and vocational factors, that she is entitled to an increased award of 80 degrees (25 percent), bringing her total award to 112 degrees (35 percent). The award made by the Determination Order shall be so modified.

ORDER

The Referee's order dated September 19, 1986 is reversed. In lieu of the Referee's award of permanent total disability and in addition to the 32 degrees (10 percent) unscheduled permanent partial disability awarded by the Determination Order, claimant is awarded 80 degrees (25 percent) unscheduled disability, bringing the total award to 112 degrees (35 percent). Claimant's attorney's fee shall be adjusted accordingly.

DALE C. HURLEY, Claimant
Hayner, et al., Claimant's Attorneys
SAIF Corp Legal, Defense Attorney
Foss, et al., Defense Attorneys

WCB 86-04526, 86-00122, 86-04524 & 86-04525
September 18, 1987
Order on Review

Reviewed by Board Members Lewis and McMurdo.

The SAIF Corporation requests review of those portions of Referee Brown's order that set aside its "de facto" denial of claimant's aggravation claim for the low back and upheld Liberty Northwest Insurance Corporation's (Liberty) partial denial of claimant's new injury claim for the same condition. SAIF asserts that Liberty's denial was a prohibited "back up" denial and that Liberty is liable by operation of law. In the alternative, SAIF argues that claimant's employment while Liberty was on the risk

independently contributed to a worsening of claimant's low back condition, thereby making Liberty responsible for claimant's claim. SAIF also asserts that claimant's aggravation claim was untimely filed. Last, SAIF requests review of that portion of the Referee's order that assessed a 25 percent penalty and an associated attorney fee against SAIF for its alleged unreasonable delay in accepting or denying claimant's aggravation claim. The issues are: (1) whether the aggravation claim filed with SAIF was timely; (2) whether Liberty's denial was prohibited; (3) if not, which insurer is responsible; and (4) penalties and attorney fees.

Claimant sustained low back injuries in 1972 and 1979 while employed by two of SAIF's insureds. The first injury resulted in two surgeries. Claimant ultimately was awarded 57.5 percent unscheduled low back disability for the effects of that injury. Following his second surgery in 1977, claimant remained symptomatic. The second injury resulted in an increased award of 10 percent. He continued to work at his regular job, however.

On June 5, 1985, while employed by Liberty's insured, claimant sustained a third injury. He fell while stepping from a truck and sustained a leg fracture. He filed a claim with Liberty, reporting the broken leg as well as a "low back and left hip sprain." Dr. Bert examined claimant four days after the injury. He later completed a first medical report in which only the left leg problem was noted. On June 17, 1985, Liberty issued a Form 1502, by which it accepted claimant's claim as disabling and incorporated the first medical report by reference. Then, on July 1, 1985, Liberty issued a second Form 1502 and specifically incorporated claimant's claim form by reference.

Throughout 1985, Liberty continued to receive the reports of Dr. Bert. Many of the reports made reference to claimant's low back pain. Ultimately, on December 27, 1985, Liberty issued a partial denial, asserting that the treatment claimant was receiving for the low back was not related to his June 1985 compensable injury.

SAIF's first argument on review is that Liberty's denial was of the "back-up" variety prohibited by Bauman v. SAIF, 295 Or 788 (1983). Under Bauman, an employer/insurer may not retroactively deny the compensability of a claim after 60 days from the date the claim was officially accepted. Liberty argues that it simply accepted claimant's claim for a leg fracture and that pursuant to Johnson v. Spectra Physics, 303 Or 49 (1987), it was not improper to deny the low back condition, which Liberty argues was never accepted.

After reviewing the record, we agree with SAIF that Liberty's denial was improper. Although claimant's 1985 claim was primarily one for a leg fracture, the claim form he submitted also clearly referred to a "low back sprain." Liberty specifically and officially accepted that condition when it incorporated claimant's claim form into its Form 1502 by reference.

The present case differs from Johnson v. Spectra Physics, supra. In Johnson, the claimant injured her back and right arm. She filed a claim with her employer, indicating that she had injured her "middle back and arm." Approximately two months later, the claimant was diagnosed as suffering from

bilateral carpal tunnel syndrome. The next month, the insurer accepted the claimant's previously filed claim for the "middle back and arm." The claimant continued to receive treatment for the carpal tunnel syndrome, and the insurer ultimately issued a partial denial of that condition. The Court of Appeals ultimately set aside the denial, holding that at the time the insurer accepted the claim, it had knowledge of the claimant's carpal tunnel syndrome and was on notice that the claimant was asserting that it was compensable. The court, therefore, held that Bauman, supra, operated to invalidate the partial denial. Johnson v. Spectra Physics, 77 Or App 1, 5 (1985). The Supreme Court reversed, noting that although the insurer had knowledge of the claimant's carpal tunnel condition, it never "specifically" or "officially" accepted it. Holding that Bauman only applies to "officially" accepted claims, the Court upheld the insurer's denial. Johnson v. Spectra Physics, 303 Or at 55.

By contrast, the present case involves a claim for a "low back sprain" that was "officially" accepted by Liberty by way of its Form 1502. Pursuant to Bauman, supra, Liberty is now estopped from retroactively denying that claim. Liberty is, therefore, responsible by operation of law. This finding moots the issue of responsibility on the merits. It also moots the issue of whether claimant timely filed an aggravation claim against SAIF.

The remaining issue is whether SAIF should have been assessed a penalty and attorney fee for an alleged untimely acceptance or denial of claimant's aggravation claim. Claimant asserts that he filed that claim with SAIF on January 14, 1986. He introduced a copy of the claim letter at the hearing. He offered no testimony, however, with regard to when or if the claim was filed. SAIF offered testimony suggesting that the claim was not received. The Referee found that it would be "reasonable to infer mailing under the circumstances." We disagree. We find that where the only evidence of the filing of the claim is a copy of the claim itself, without accompanying testimony regarding the time and/or method of filing, claimant has failed to prove that the claim was received by SAIF. The Referee's assessment of penalties and attorney fees will be reversed.

ORDER

The Referee's order dated November 11, 1986 is reversed in part and affirmed in part. Those portions of the order that set aside the SAIF Corporation's "de facto" denial of claimant's aggravation claim, upheld Liberty Northwest Insurance Corporation's partial denial of compensability, and assessed a penalty and associated attorney fee against SAIF are reversed. Claimant's low back claim is remanded to Liberty for processing according to law. Liberty shall reimburse SAIF for costs incurred in processing claimant's claim thus far and shall pay the attorney fee awarded by the Referee for services at hearing. The remainder of the Referee's order is affirmed. Claimant's attorney is awarded $550 for services on Board review, to be paid by Liberty.

ERNEST E. ROBINETTE, Claimant
E. Jay Perry, Defense Attorney

WCB 84-01437
September 18, 1987
Order on Review

Reviewed by Board Members McMurdo and Lewis.

Claimant requests review of Referee Seymour's order that upheld the insurer's denial of claimant's injury claim for a hernia condition. Claimant has also submitted various documents on review not contained in the record. We construe this as a motion for remand. The issues are compensability and 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 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 (1986); Delfina P. Lopez, 37 Van Natta 164 (1985).

We are not persuaded that the aforementioned documents were not obtainable with due diligence at the time of the hearing. Consequently, we decline to grant claimant's motion for remand.

The Board affirms the order of the Referee.

ORDER

The Referee's order dated September 12, 1986 is affirmed.

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

WCB 85-06114, 85-08255, 85-12276 & 86-03455
September 21, 1987
Order on Review

Reviewed by Board Members Ferris and Lewis.

Liberty Northwest Insurance Corporation (Liberty) requests review of that portion of Referee Mongrain's order that set aside its denial of claimant's medical services claim for the left and right shoulders subsequent to July 1, 1983. The SAIF Corporation has not formally requested review, but it asks in its brief that we overturn the Referee's order insofar as it set aside SAIF's denial of claimant's medical services claim for the shoulders for the period of July 1, 1981 through June 30, 1983. The issue is which of three insurers is responsible for claimant's medical services claim. We modify the Referee's order.

Claimant sustained a compensable right shoulder injury in August 1976 while employed by Burrill Lumber Company, then insured by EBI. While still working for Burrill, he sustained an injury to the left shoulder in January 1978. Again, EBI was on the risk and it accepted claimant's claim as nondisabling. Although claimant complained of bilateral shoulder problems thereafter, he continued to work.

On July 1, 1981, SAIF became Burrill's insurer. Its coverage ran through June 30, 1983, when Liberty became the insurer. Liberty remained the insurer as of the time of the hearing.

After the 1976 and 1978 injuries, claimant received regular chiropractic care, but did not submit billings because of his belief that they would not be paid. He also continued working throughout Burrill's three periods of insurance coverage, and he continued to work as of the time of the hearing.

In November 1984, Dr. McIntosh, an orthopedist, diagnosed bilateral rotator cuff impingement and a subsequent arthrogram revealed a torn right rotator cuff. McIntosh's billings and billings for radiological services were submitted to EBI, which issued a denial thereof on May 1, 1985. Claimant subsequently filed claims with SAIF and Liberty, asserting that each period of employment contributed to a worsening of his condition. The claim with Liberty was filed on May 15, 1985. Each insurer ultimately issued a denial of responsibility.

The Referee found that there was persuasive medical evidence that claimant's shoulder conditions were caused by his employment during the period of EBI's coverage. He also found persuasive evidence that claimant's employment continued to contribute to a worsening of his shoulder conditions during the second period of coverage, during which SAIF was on the risk, and the third period of coverage, during which Liberty was the insurer.

Relying on Bracke v. Baza'r, Inc., 293 Or 239 (1982), the Referee allocated responsibility for claimant's medical services to each insurer for the specific period in which it was on the risk. He therefore held EBI liable up through the date SAIF assumed coverage, and SAIF liable up through the date Liberty came on the risk. He held Liberty responsible thereafter.

On review, EBI argues that the Referee's allocation of responsibility was proper. SAIF argues that the employment during the second period of coverage did not contribute to claimant's condition, and that EBI, the first insurer, should remain responsible. Liberty argues that the Referee's allocation of responsibility represented an improper "apportionment," and that responsibility should have remained with EBI.

First, we agree with the Referee that each of the periods of employment contributed to the causation of claimant's underlying shoulder conditions. See Hensel Phelps Construction Co. v. Mirich, 81 Or App 290 (1986).

We disagree, however, with the Referee's three-way allocation of responsibility. In a successive injury case, if a worker presents substantial evidence of successive work-related injuries, a prima facie case for recovery from the last employer/insurer is made out. If the trier of fact is convinced that claimant's injury was caused by successive work-related incidents but is unconvinced that any one employment is the more likely cause, the finding is for the worker against the last employer. Boise Cascade Corp. v. Starbuck, 296 Or 238, 244-45 (1984); Mirich, supra.

As mentioned above, there is persuasive evidence that claimant's employment during the period in which Liberty was on the risk independently contributed to a worsening of his underlying condition. By operation of "the last injury rule," Liberty is responsible for the entire period of claimant's claim.

Although we can understand why the Referee chose to allocate responsibility among the insurers in this complicated case, we do not believe that such allocation is permissible. Liberty, therefore, is responsible.

ORDER

The Referee's order dated June 17, 1986 is modified. In lieu of the Referee's allocation of responsibility for claimant's medical services claim among EBI Companies, the SAIF Corporation and Liberty Northwest Insurance Corporation, claimant's medical services claim is remanded to Liberty for processing according to law.

MARIA N. FLORES, Claimant
Pozzi, et al., Claimant's Attorneys
Carrol Smith (SAIF), Defense Attorney
Bottini, et al., Defense Attorneys

WCB 86-11534 & 85-05626
September 21, 1987
Order on Review

Reviewed by Board Members Ferris and Lewis.

Mission Insurance Company requests review of Referee Mulder's order that: (1) set aside its denial of medical services for claimant's head condition; and (2) upheld the SAIF Corporation's denial of claimant's aggravation claim and its "de facto" denial of claimant's medical services claim for the same condition. The issues are compensability and responsibility.

Claimant, 44 at the time of hearing, sustained a compensable head injury in July 1981. At that time, the employer was insured by Mission. Shortly thereafter, claimant sought treatment from Dr. Yand, her family physician, for headaches and visual abnormalities. Yand diagnosed a scalp hematoma and a mild cerebral concussion. X-rays subsequently revealed a small fracture in the vertex area of claimant's scalp. Despite continuing headaches and nausea, claimant returned to regular work as a food service worker in November 1981. A Determination Order issued in August 1982, awarding temporary disability only.

In September 1982, SAIF became the employer's insurer. Claimant apparently reinjured her head in May 1982, in August or October 1983, and in March 1984. Although claimant testified that she filled out claim forms for each of those reinjuries, no claim was ever processed. A few days after her March 1984 reinjury, she was examined by Dr. Aversano, an osteopath. Aversano noted that claimant had experienced "different types of pain" after each of her head reinjuries.

In June 1984, claimant sustained a nondisabling compensable injury to her head. She was seen by Dr. Yand, who diagnosed a hematoma and released her to regular work. A few weeks later, she was examined by Dr. Raaf, neurosurgeon. According to Raaf, claimant's ongoing headaches were due to an "anxiety tension state" and were no longer related to her 1981 injury. In September 1984, Dr. Aversano concurred with Raff's assessment and agreed that no further medical treatment, other than psychiatric techniques, was necessary.

In October 1984, a Determination Order classified the June 1984 injury as nondisabling and awarded no compensation.

In March 1985, Mission denied responsibility for further medical treatment of claimant's head condition. After appealing the

denial, claimant requested the Hearings Division to issue an order joining SAIF as a party. Claimant also apparently requested an order designating a paying agent pursuant to ORS 656.307 order. A month later, the Hearings Division issued an order joining SAIF as a party. A .307 order was never issued.

In February 1986, Dr. Rosenbaum, neurologist, reviewed claimant's medical records. Noting that claimant had apparently gone without medical treatment from March 1982 to December 1983, Rosenbaum felt that it was "unlikely" claimant's headaches were related to her July 1981 injury. He concluded that claimant's headaches were due to either "posttraumatic headaches" or an "anxiety tension state." That same month, Dr. Robinson, opthalmologist, reported that there was no relationship between claimant's then current headaches and her July 1981 injury. In June 1986, Dr. Yand opined that the 1981 injury was "a major contributing cause" of claimant's continuing difficulties. Yand added, however, that "the [July 1981] injury seems to have been resolved, but the symptom patterns attributable to the injury continued into early 1984." In July 1986, Dr. Aversano advised that claimant's headaches were related to her July 1981 injury. Yet, a few months later, Aversano stated that he "concur[ed] with Drs. Raaf, Rosenbaum and Robinson."

In August 1986, SAIF denied reopening of claimant's claim on the basis that her ongoing head problems were the result of her July 1981 injury.

Claimant testified that following her 1982 reinjury, she began to miss work on a regular basis due to headache pain. She also felt that her memory began to deteriorate after the 1982 reinjury. She stated that she saw Dr. Yand "continuously" between 1981 and 1983. After March 1984, she apparently began having crying spells and her work hours were reduced as a result of increased absenteeism. She felt her head difficulties had been "continuous" since her July 1981 injury.

At the hearing, Mission conceded the compensability of claimant's continuing need for medical treatment. SAIF, however, made it clear that it was contesting the compensability of claimant's aggravation claim, as well as responsibility. The Referee analyzed the case under the rule announced in Industrial Indemnity Co. v. Kearns, 70 Or App 583 (1984). Concluding that claimant had experienced recurrent symptoms following her July 1981 injury, the Referee assigned responsibility to Mission. We disagree.

In our view, Kearns, supra, is not applicable to the instant case. In Kearns, the claimant sustained two compensable injuries during 1979. A different insurer was providing coverage at the time of each injury and each accepted the injury which occurred during its coverage. Subsequently, the claimant's physician requested claim reopening without specifying on which of the 1979 injuries he was relying. Both insurers denied an aggravation solely on the basis of responsibility. 70 Or App at 585.

Here, unlike Kearns, compensability was at issue. Although Mission conceded compensability, SAIF did not. At the hearing SAIF's attorney stated:

> "It's SAIF's position that compensability is an issue as well as responsibility."

"Claimant has since left the employ of [the employer] and it's our position that any current tension state would no longer be related to the nondisabling laceration for which SAIF accepted in 1984."

In our view, this is not solely a responsibility case. Claimant must, therefore, prove compensability.

First, we examine Mission's denial of medical services. For every compensable injury, the employer 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).

Here, Drs. Raaf and Rosenbaum opined that claimant's continuing head problems were due to an "anxiety tension state," rather than her July 1981 injury. Rosenbaum based his opinion on a history that indicated a lack of medical treatment for over a year-and-a-half following the July 1981 injury. Despite claimant's testimony to the contrary, Dr. Yand's chart notes corroborate such a history. Dr. Robinson unequivocally stated there was no relationship between claimant's continuing complaints and her July 1981 injury. Dr. Aversano opined that claimant's headaches were related to her July 1981 injury, but he also twice concurred with the opinion of Dr. Raaf. Thus, we assign little weight to Aversano's contradictory opinion. Lastly, Dr. Yand opined that claimant's ongoing head problems were related to her July 1981 injury. Yand, however, also stated that the July 1981 injury had "resolved" and that the symptoms attributable thereto continued only "into early 1984." We are persuaded by the well reasoned and uncontradictory opinions of Drs. Raaf, Rosenbaum, and Robinson. Somers v. SAIF, 77 Or App 259, 263 (1986). Claimant has not established that her current need for medical treatment is materially related to her July 1981 injury.

We now turn to SAIF's denial of an aggravation and its "de facto" denial of the medical services claim. To prove an aggravation claimant must show: (1) a worsening of her condition since the last arrangement of compensation that renders her more disabled, i.e., less able to work; and (2) a causal relationship between the worsened condition and the compensable injury. ORS 656.273(1); Smith v. SAIF, 302 Or 396 (1986); Stepp v. SAIF, 78 Or App 438 (1986).

Here, the last arrangement of compensation was the October 1984 Determination Order. None of the medical experts indicated that claimant's head condition materially worsened after October 1984. In addition, none of the medical experts indicated that any alleged worsening was materially related to claimant's June 1984 injury. After considering claimant's testimony that her symptoms were "continuous" following her July 1981 injury, as well as the medical evidence, we are not persuaded that claimant has established either a compensable aggravation or medical services claim. Accordingly, we agree with the Referee that SAIF's denial should be upheld.

ORDER

The Referee's order dated November 3, 1986 is reversed in part and affirmed in part. Mission Insurance Company's denial

is reinstated and upheld. The remainder of the Referee's order is affirmed.

JOHN L. KATZENBACH, Claimant
Robert L. Chapman, Claimant's Attorney
Cowling & Heysell, Defense Attorneys

WCB 85-14924
September 21, 1987
Order on Review

Reviewed by Board Members Ferris and McMurdo.

Claimant requests review of Referee Mongrain's order that upheld the self-insured employer's partial denial of medical services as no longer related to claimant's compensable right wrist injury. The issue is medical services.

Claimant, 23 years of age at the time of the hearing, sustained a compensable right wrist injury in June 1985. Shortly thereafter, he was seen by Dr. Affley, who diagnosed tendinitis, but noted that an x-ray would be necessary if claimant's pain persisted. He then prescribed a wrist brace and recommended light-duty work.

In November 1985, claimant reported to Dr. Broussard, with complaints of swelling in the right forearm. X-rays were taken, which showed an aseptic necrosis on the lunate bone of claimant's right wrist.

The employer denied further medical services for claimant's right wrist as allegedly no longer related to his accepted condition. In its partial denial, the employer acknowledged that claimant was seeking treatment "for the same or similar symptoms." The Referee upheld the denial. We reverse.

Recently, in Ana M. Guerrero, 39 Van Natta 1 (1987), we stated:

> "A partial denial of a previously accepted inseparable condition, issued while the claim is in open status, is not permissible. Roller v. Weyerhaeuser Co., 67 Or App 583 (1984); Safstrom v. Riedel International, Inc., 65 Or App 728 (1983)."

Here, claimant's right wrist claim was still in open status when the employer issued its partial denial. We are unable to separate claimant's need for medical services related to his accepted right wrist condition from those attributable to his allegedly noncompensable "aseptic necrosis." Therefore, we find the employer's partial denial, prior to claim closure, impermissible.

ORDER

The Referee's order dated November 24, 1986 is reversed. The employer's partial denial is set aside. Claimant's attorney is awarded $1,000 for his services at hearing and $500 for services on Board review, to be paid by the self-insured employer.

BARBARA J. MEHERIN, Claimant
Michael B. Dye, Claimant's Attorney
Roberts, et al., Defense Attorneys

WCB 86-00160
September 21, 1987
Order on Review

Reviewed by Board Members Ferris and McMurdo.

The self-insured employer requests review of Referee Michael V. Johnson's order that: (1) set aside its denials of claimant's scoliosis condition; (2) set aside the Determination Order dated December 19, 1985 as premature; and (3) refused to rate the extent of claimant's unscheduled permanent partial disability relating to her back. In her brief on Board review, claimant argues that the Referee erred in not assessing penalties and attorney fees on the ground that the employer's denials of her scoliosis condition were unreasonable. The issues are the procedural propriety of the insurer's denials, the compensability of claimant's scoliosis condition, premature closure, extent of disability, penalties and attorney fees.

The Board affirms the order of the Referee with the exception of that portion that found claimant's scoliosis condition compensable. The Referee set aside the employer's denials of the condition on the ground that the employer had "de facto" accepted the condition and could not subsequently deny it without violating the rule of Bauman v. SAIF, 295 Or 788 (1983). After the Referee issued his order, the Supreme Court ruled that Bauman does not apply to a condition until it has been formally accepted. Johnson v. Spectra Physics, 303 Or 49 (1987). The denials, therefore, were proper under Bauman. As for the relationship between the compensable back injury and claimant's scoliosis condition, this must first be assessed by the Evaluation Division when the claim is submitted for closure pursuant to ORS 656.268. See Roller v. Weyerhaeuser Co., 67 Or App 583, 586-87, amplified, 68 Or App 743, rev den 297 Or 601 (1984); Safstrom v. Riedel International, Inc., 65 Or App 728, 731-32 (1983), rev den 297 Or 124 (1984).

ORDER

The Referee's order dated August 22, 1986 is affirmed. Claimant's attorney is awarded $400 for services on Board review, to be paid by the self-insured employer.

JOANN C. VOHS, Claimant
Welch, et al., Claimant's Attorneys
Beers, et al., Defense Attorneys
Cliff, et al., Defense Attorneys
Schwabe, et al., Defense Attorneys

WCB 85-08680, 85-12626 & 86-0840
September 21, 1987
Order on Review

Reviewed by Board Members Ferris and Lewis.

Aetna Casualty Company requests review of Referee Leahy's order that set aside its denial of claimant's occupational disease claim relating to her low back. The issue is responsibility.

Claimant began working as a cook for a nursing facility in July 1978. Her job involved a significant amount of bending, twisting and lifting. EBI Companies was the insurer from the time that claimant began her job until the end of March 1983, when Industrial Indemnity Company became the insurer. Claimant began

experiencing low back and right leg pain in 1980, which gradually increased. In early 1984, she experienced new pain in her buttocks and, in May 1984, sought medical attention. Dr. Erickson, the attending physician, ordered a CT scan which revealed evidence of degenerative changes in the L4-5 and L5-S1 discs. Physical therapy was recommended, but claimant did not pursue it because of the expense. Claimant personally associated her back condition with her employment, but did not file a claim at that time. None of the contemporaneous medical records discuss the cause of the condition. Claimant submitted the medical bills to her health insurance carrier. She did not miss any work as a result of her back pain or medical treatment. However, she did request and was granted less strenuous work.

Industrial Indemnity continued on the risk until April 1, 1985, when Aetna became the insurer. A week after Aetna came on the risk, claimant visited Dr. Berkeley, a neurosurgeon. Dr. Berkeley ordered a CT scan and a myelogram which were carried out later the same month. After reviewing the results, Dr. Berkeley diagnosed lateral recess stenosis secondary to osteophytic spurring and facet hypertrophy and recommended surgery. Claimant continued to work until the end of May, when she underwent the recommended surgery.

In two written reports, Dr. Berkeley opined that claimant's condition was due to her employment activity. In a later deposition, he reiterated this conclusion and upon further questioning stated, on a theoretical level, that each day that claimant had worked had caused further deterioration of her condition. He also stated, however, that between the time that claimant was examined by Dr. Erickson in May 1984 and the time that he performed surgery in May 1985, there was no objective change in her condition. In addition, he stated that during the last eight weeks of her employment (when Aetna was on the risk), there was no change in the nature or level of her symptoms. This was confirmed by claimant at the hearing.

The Referee held that because claimant did not file a claim until Aetna was on the risk and her employment after that time "could have" caused her condition, Aetna was responsible. In the alternative, the Referee found that claimant had sustained a pathological worsening of her underlying condition during the time that Aetna was on the risk.

We disagree with the Referee's analysis. The rule which applies in this case was summarized in Boise Cascade Corp. v. Starbuck, 296 Or 238, 243 (1984):

> "In an occupational disease context, if a disease is contracted and disability occurs during one employment as a result of conditions of that employment, even though work conditions at a later employment could have caused that disease, the earlier employer is liable if the later employment 'did not contribute to the cause of, aggravate, or exacerbate the underlying disease.' Bracke [v. Baza'r, Inc., 293 Or 239, 250 (1982)]."

Claimant's disability began when she sought medical

treatment for her condition in May 1984 while Industrial Indemnity was on the risk. See United Pacific Insurance Co. v. Harris, 63 Or App 256, 260, rev den 295 Or 730 (1983). Industrial Indemnity is responsible, therefore, unless claimant's employment after April 1, 1985, when Aetna came on the risk, independently contributed to a worsening of her underlying condition.

Although Dr. Berkeley stated on a theoretical level that every day of the six and one-half years that claimant worked for the employer contributed to a worsening of her condition, the clinical evidence establishes that no perceptible worsening in fact occurred during the last eight weeks of her employment. Because there was no such worsening, liability for claimant's condition did not shift to Aetna and Industrial Indemnity remains the responsible insurer.

ORDER

The Referee's order dated November 28, 1986 is affirmed in part and reversed in part. Those portions of the order that upheld Industrial Indemnity's July 3, 1985 denial and set aside Aetna's July 31, 1985 denial are reversed. Aetna's denial is reinstated and upheld. Industrial Indemnity's denial is set aside and the claim is remanded to Industrial Indemnity for processing. In addition, Industrial Indemnity shall reimburse Aetna for its claim costs to date. The remainder of the order is affirmed.

GARY WILLIAMS, Claimant
Corl & Street, Claimant's Attorneys
SAIF Corp Legal, Defense Attorney

WCB 85-11171
September 21, 1987
Order on Review (Remanding)

Reviewed by Board Members Ferris and Lewis.

Claimant requests review of that portion of Referee Michael Johnson's Order on Reconsideration that upheld the SAIF Corporation's denial of his aggravation claim. Claimant requests remand for the consideration of additional evidence. In its brief, SAIF requests review of that portion of the Order on Reconsideration that: (1) increased claimant's rate of temporary disability and assessed a penalty and attorney fee for an improper calculation. The issues are remand, temporary disability, penalties and attorney fees.

Hearing on this matter convened in February 1986 and the record was closed in May 1986. At the time of hearing, claimant was diagnosed as having recurrent lumbosacral strain with little evidence of worsening since a July 1985 Determination Order. In March 1986 claimant began treatment with Dr. Knox, neurologist, who requested authorization to perform an EMG. This was the first time such a test had been proposed. In June 1986 Dr. Lewis reported that claimant had a history of chronic low back pain which was essentially unchanged from previous examinations. Dr. Lewis noted that a CT scan had been negative, but stated that the S-1 nerve root should be further evaluated and concurred in Dr. Knox's request to perform an EMG of the right lower extremity and back.

On June 27, 1986, Dr. Knox performed an EMG and diagnosed: (1) probable irritative L5-S1 radiculopathy associated with distal mild neurogenic atrophy; and (2) superimposed mild mononeuropathy involving the left tibial nerve. Based on these findings and his examinations since March, Dr. Knox advised that claimant had experienced a worsening. Claimant requests remand for admission of these findings and reports into evidence.

We may remand to the Referee if we find that the record has been "improperly, incompletely or otherwise insufficiently developed." ORS 656.295(5). Generally, where claimant has never had an adequate explanation for a chronic condition, the record may be reopened to clarify claimant's condition. Egge v. Nu-Steel, 57 Or App 327, rev den 293 Or 456 (1982). To merit remand, the newly discovered evidence must not have been obtainable with due diligence before the hearing. Delfina Lopez, 37 Van Natta 164, 170 (1985).

Here, claimant has never had an adequate explanation for his lumbosacral back pain. The EMG provided a new explanation for his complaints of pain not available prior to the hearing. We conclude that the EMG and Dr. Knox's report constituted new evidence that could not have been obtained prior to hearing with due diligence. Accordingly, this matter is remanded for the taking of additional evidence, solely with regard to the issue of aggravation.

ORDER

The Referee's Order on Reconsideration dated July 17, 1986 is vacated and this matter is remanded to the Hearings Division for further proceedings consistent with this order.

FLORENCE J. AMES, Claimant
Peter O. Hansen, Claimant's Attorneys
Annala, et al., Defense Attorneys

WCB 86-08069
September 22, 1987
Order on Review

Reviewed by Board Members McMurdo and Lewis.

The self-insured employer requests review of that portion of Referee Gary Peterson's order that set aside its partial denial of claimant's current psychological condition. Claimant cross-requests review of that portion of the Referee's order that upheld the employer's denial of claimant's aggravation claim for her compensable right elbow injury. On review, the issues are compensability and aggravation.

With her cross-request and brief, claimant has enclosed copies of several chart notes and reports, some of which were not admitted as evidence at the hearing. We treat this submission as a request for remand for the taking of additional evidence. Judy A. Britton, 37 Van Natta 1262 (1985). The request is denied. After conducting our de novo review, we find that the record has not been "improperly, incompletely or otherwise insufficiently developed." See ORS 656.295(5). Moreover, it has not been shown that the evidence relevant to the issues raised in this matter 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).

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

Finally, we find the compensability of claimant's current psychological condition to have been of ordinary difficulty with the usual probability of success on review. Accordingly, a reasonable attorney fee is awarded.

ORDER

The Referee's order dated October 24, 1986 is affirmed. For services on Board review concerning the compensability of claimant's current psychological condition, claimant's attorney is awarded $500, to be paid by the self-insured employer.

KATHY S. BASSHAM, Claimant
W.D. Bates, Jr., Claimant's Attorney
E. Jay Perry, Defense Attorney

WCB 86-08479
September 22, 1987
Order on Review

Reviewed by Board Members Ferris and Lewis.

The insurer requests review of Referee Garaventa's order which awarded 25 percent (37.5 degrees) scheduled permanent partial disability for loss of use or function of the left forearm (wrist), whereas a September 13, 1985 Determination Order had awarded five percent (7.5 degrees). On review, the insurer contends that the Referee's award should be reversed. We agree and modify.

Claimant was 43 years of age at the time of hearing. On March 7, 1985, she sustained a compensable left wrist fracture while working as a plugger operator. Claimant slipped on a piece of veneer, fell from a platform and landed on her left arm, fracturing the distal radius and midshaft of her left forearm.

Claimant was treated by Dr. Nagel, an orthopedic surgeon. Although a cast was applied, no surgery was required. In June, 1985, she was released to modified work, subject to a temporary five pound lifting restriction. Following a May 1987 evaluation, Dr. Nagel opined that claimant suffered some residual impairment in the form of a 10 degree loss of ulnar flexion. However, Dr. Nagel noted that claimant's wrist and forearm strength were normal.

Claimant has continued to work, but she wears a brace to support her wrist. She had been wearing a canvas brace, but a leather brace subsequently became necessary. She also wears the brace at home, when attempting any lifting activities. As her wrist tires, claimant experiences pain, which extends into her fingers and up towards her elbow. Although the brace is necessary for claimant to work, she acknowledges a loss of wrist mobility while wearing the brace. Claimant's supervisor testified that claimant probably performs 90 percent of the work that she performed prior to the wrist injury, and that she is still a good worker.

The Referee found claimant's testimony particularly believable. Taking into consideration claimant's diminished ulnar flexion, pain and credible testimony, the Referee increased claimant's scheduled permanent disability award from five percent to 25 percent.

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). The administrative rules set forth guidelines to assist in the determination of the extent of permanent disability. See OAR 436-30-000, et seq. In addition to these guidelines, however, disabling pain resulting from the injury is to be considered. Garbutt v. SAIF, 297 Or 148, 151 (1984); see also Richard S. Cosner, 38 Van Natta 1555, 1558 (1986); Jim Warner, 38 Van Natta 549 (1986).

Following our de novo review of the medical and lay evidence, which includes claimant's believeable testimony, we are persuaded that she is entitled to an award of scheduled permanent partial disability greater than that awarded by the Determination Order. However, we find the Referee's award to be excessive. After completing our review and considering the above mentioned guidelines, we conclude that an award of 15 percent scheduled permanent partial disability adequately compensates claimant for her compensable injury.

ORDER

The Referee's order dated January 30, 1987 is modified. In lieu of the Referee's award and in addition to the five percent (7.5 degrees) scheduled permanent partial disability awarded by the September 13, 1985 Determination Order, claimant is awarded 10 percent (15 degrees), for a total award to date of 15 percent (22.5 degrees) scheduled permanent partial disability for loss of use or function of the left forearm (wrist). Claimant's attorney fee shall be adjusted accordingly.

ANA TEPEI, Claimant
Peter O. Hansen, Claimant's Attorney
SAIF Corp Legal, Defense Attorney
Acker, et al., Defense Attorneys

WCB 86-02893 & 86-09576
September 22, 1987
Order on Review

Reviewed by Board Members Lewis and McMurdo.

Claimant requests review of Referee Mulder's order that upheld Liberty Northwest Insurance Corporation's denial of her occupational disease claim relating to her left upper extremity and set aside the SAIF Corporation's denial of a similar claim for the same condition. The issue is responsibility.

Claimant began working as a seamstress for the employer in mid-1983. In November 1985, she sought treatment for pain in her left arm and shoulder and missed five days of work. The problem was treated conservatively without a specific diagnosis. SAIF was the insurer at the time. Claimant returned to work and continued to experience symptoms. Liberty Northwest became the insurer on January 1, 1986.

At the end of January 1986, claimant again sought medical treatment and was taken off work. At that time, her condition was diagnosed as subscapular bursitis. A few months later, claimant began treating with Dr. Long, a specialist in physical medicine and rehabilitation. He diagnosed the condition as left carpal tunnel syndrome with diffuse myofascial pain syndrome of the left shoulder and indicated that it had developed in October 1985 as a result of her work as a seamstress.

When later questioned regarding whether claimant's work activity after January 1, 1986 had worsened her underlying condition, Dr. Long replied in the affirmative. His opinion was based upon history received from claimant to the effect that her symptoms worsened considerably during January 1986. This history was confirmed in claimant's testimony and corroborated by the testimony of a coworker.

In his Opinion and Order, the Referee held that SAIF, the first insurer, was responsible because "claimant's work during coverage by both insurer's caused symptom onset and caused claimant to become disabled from work." When SAIF requested reconsideration, the Referee reiterated his conclusion in a supplementary order. In the supplementary order, the Referee appears to conclude that claimant's underlying condition did not worsen after January 1, 1986 based on the Court of Appeals' interpretation of an opinion expressed by Dr. Long in another case, SAIF v. Luhrs, 63 Or App 78, 84-85 (1983).

We disagree with the Referee's analysis. The rule which applies in this case was summarized in Boise Cascade Corp. v. Starbuck, 296 Or 238, 243 (1984):

> "In an occupational disease context, if a disease is contracted and disability occurs during one employment as a result of conditions of that employment, even though work conditions at a later employment could have caused that disease, the earlier employer is liable if the later employment 'did not contribute to the cause of, aggravate, or exacerbate the underlying disease.' Bracke [v. Baza'r, Inc., 293 Or 239, 250 (1982)]."

Claimant's disability began in the present case when she sought medical treatment for her condition in November 1985 while SAIF was on the risk. See United Pacific Insurance Co. v. Harris, 63 Or App 256, 260, rev den 295 Or 730 (1983). SAIF is responsible, therefore, unless claimant's employment after January 1, 1986 independently contributed to a worsening of her underlying condition.

After our de novo review of the record, we conclude that claimant's work activity after January 1, 1986 did independently contribute to a worsening of her underlying condition. This was the opinion of Dr. Long and was supported by the lay testimony. In reaching a contrary conclusion, the Referee supplemented the record with the Court of Appeals' interpretation of an opinion by Dr. Long in another case. This was improper. See Rosa Martinez, 39 Van Natta 336 (1987); Judy J. Gornick, 39 Van Natta 159, 161 (1987). We conclude, therefore, that Liberty Northwest is responsible.

ORDER

The Referee's order dated October 9, 1986, as supplemented and reissued by the order dated December 3, 1986, is reversed. The SAIF Corporation's denial dated July 9, 1986 is reinstated and upheld. Liberty Northwest Insurance Corporation's denial dated February 13, 1986 is set aside and the claim is remanded to that insurer for processing. The attorney fee awarded by the Referee for services at the hearing shall be paid by Liberty Northwest. In addition, claimant's attorney is awarded $500 for services on Board review, to be paid by Liberty Northwest.

VELTON L. BRIDGES, Claimant
Malagon & Moore, Claimant's Attorneys
Williams, et al., Defense Attorneys

Own Motion 81-0049M
September 23, 1987
Own Motion Determination on Reconsideration

The Board issued an Own Motion Determination on May 13, 1987 whereby claimant's claim was closed with no additional award for permanent partial disability. Claimant seeks an increased award, including possible permanent total disability. The insurer contends claimant cannot legally request reconsideration.

The standard language printed at the bottom of our own motion orders applies to appeals to the Court of Appeal, not to requests for reconsideration of our prior own motion orders. OAR 438-12-015. The Board's longstanding policy has been to allow reconsideration of its own motion orders if the request is made within a reasonable period of time after the issuance of the prior order. We consider Claimant's timely.

After thorough consideration of the evidence, we conclude claimant's condition is worse than it was at the time of the last closure. We do not find he is permanently and totally disabled, however. Claimant is hereby granted an additional award for 64 degrees for 20 percent unscheduled disability resulting in a total award of 272 degrees for 85 percent unscheduled disability. Claimant's attorney is awarded 25% of the additional compensation granted by this order, not to exceed $400 as a reasonable attorney's fee.

IT IS SO ORDERED.

JACOBA C. (WESTON) CURTIS, Claimant
Olson Law Firm, Claimant's Attorney
Rankin, et al., Defense Attorneys

WCB 86-00838
September 24, 1987
Order on Review

Reviewed by Board Members McMurdo and Lewis.

Claimant requests review of Referee Galton's order that: (1) upheld the insurer's denials of claimant's aggravation and medical services claims relating to her low back; and (2) affirmed a Determination Order which awarded no permanent partial disability for the same condition. The issues are responsibility, aggravation, medical services and extent of disability.

Claimant injured her low back in October 1983. The injury was treated conservatively and the claim was closed by Determination Order in December 1985 with no award of permanent disability. In February 1986, claimant began treating with Dr. Cannard, a chiropractor, at the rate of about three times per week. Treatment included the low back, but appears to have been directed primarily toward the neck and upper back.

In May 1986, claimant began working as a clerk at a grocery store and began complaining to Dr. Cannard of increased low back pain which she associated with the amount of standing required by her new job. On July 17, 1986, the insurer issued a denial of chiropractic treatments in excess of two per month on the ground that such treatments were not reasonable and necessary. Dr. Cannard advised the insurer that an increased treatment schedule was necessary because of increased low back symptoms relating to claimant's new employment and that he was taking claimant off work as of July 21, 1986. The insurer issued

an aggravation denial on September 8, 1986 on two alternative grounds: (1) that claimant's low back condition had not worsened; or (2) that the condition had become the responsibility of the new employer.

Dr. Cannard declared claimant medically stationary as of September 17, 1986, but gave no rating of impairment. Drs. Gatterman and Fabricius, consulting chiropractors, rated claimant's impairment at zero after an independent medical examination in late August 1986.

The Referee found that claimant's employment during mid-1986 had independently contributed to a worsening of her underlying low back condition and held that responsibility for that condition rested with her latest employer. On this basis, he upheld the insurer's aggravation denial and that portion of the medical services denial relating to treatment rendered after July 21, 1986. Claimant's latest employer was not a party to the proceeding. The Referee also upheld that portion of the medical services denial relating to treatments rendered prior to July 21, 1986, but on the ground that treatments in excess of two per month were not reasonable and necessary. Regarding the issue of extent of disability, the Referee affirmed the Determination Order which had granted no permanent disability award.

We affirm those portions of the Referee's order that affirmed the Determination Order and upheld that portion of the insurer's medical services denial relating to treatment rendered prior to July 21, 1986. Regarding the aggravation denial and the denial of chiropractic treatment after July 21, 1986, however, we reverse.

After the Referee issued his order, the Supreme Court ruled in Runft v. SAIF, 303 Or 493 (1987) that responsibility may not be shifted to an employer which has not been joined as a party by the other potentially responsible parties. Responsibility for claimant's low back condition, therefore, remains with the insurer. After our de novo review of the record, we conclude that claimant sustained a compensable aggravation of her low back condition on July 21, 1986 which also required increased medical treatment. Hence, the insurer's aggravation denial and that portion of the medical services denial relating to treatment of claimant's low back condition after July 21, 1986 must be set aside. Claimant became medically stationary on September 17, 1986. The evidence does not indicate that her July 1986 aggravation resulted in any permanent impairment. No permanent disability award, therefore, will be granted.

ORDER

The Referee's order dated October 9, 1986 is affirmed in part and reversed in part. Those portions of the order that upheld the insurer's aggravation denial dated September 8, 1986 and upheld that portion of the insurer's medical services denial dated July 17, 1986 relating to treatment rendered after July 21, 1986 are reversed. The insurer shall pay claimant temporary total disability for the period beginning July 21, 1986 and ending September 17, 1986 and for low back chiropractic treatments in excess of two per month during this period. The remainder of the order is affirmed. Claimant's attorney is awarded $1,000 for services at the hearing and $500 for services on Board review, to be paid by the insurer.

REFUGIO GUZMAN, Claimant
Ginsburg, et al., Claimant's Attorney
Larry Dawson, Defense Attorney
Cummins, et al., Defense Attorneys

WCB 86-06699 & 86-09702
September 24, 1987
Order on Reconsideration (Remanding)

AMFAC, a self-insured employer, has requested reconsideration of the Board's Order on Review dated August 31, 1987 that reversed that portion of Referee Podnar's order which found AMFAC responsible for claimant's low back condition. Pursuant to our order, Northwest Farm Bureau's denial of claimant's "new injury" claim for a low back condition was set aside and AMFAC's denial of claimant's aggravation claim was upheld.

AMFAC seeks clarification of our order, asking that we specify what portion of the Referee's order was affirmed. Upon further consideration, we agree with AMFAC's assertion that the Referee's order was reversed in its entirety. Therefore, the reference in our prior order to a partial affirmation is deleted.

Secondly, AMFAC requests that we determine the extent of claimant's unscheduled permanent disability attributable to his November 1983 injury, for which AMFAC is responsible. Since Northwest Farm Bureau is now responsible for claimant's low back condition, AMFAC is correct in asserting that this disability determination should be made as of the date of claimant's March 4, 1986 "new injury." Evidence concerning the extent of permanent disability issue was presented at the hearing before Referee Podnar. Yet, because the Referee found that claimant had suffered an aggravation, rather than a "new injury," this issue was deferred as premature. Consequently, this issue was not addressed in the Referee's order.

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

In view of the Referee's responsibility finding, relevant facts concerning the extent of claimant's permanent disability were neither discussed nor analyzed. Moreover, the Referee did not evaluate claimant's testimony as it pertained to any disabling pain complaints or physical limitations. We consider such an analysis essential to a determination of the extent of claimant's permanent disability. Thus, we find that this issue has been insufficiently developed.

AMFAC suggests that this issue be remanded for consolidation with a presently pending hearing which concerns the extent of claimant's current permanent disability. See WCB Case No. 87-06137. We concur with this suggestion. Therefore, this matter is remanded to the Presiding Referee with instructions to consolidate this issue with the current hearing request in WCB Case No. 87-06137. Once consolidation is achieved, the Presiding Referee shall refer this matter to the Referee scheduled to consider the issues raised in WCB Case No. 87-06137. The Hearings Referee is instructed to determine the extent of claimant's unscheduled permanent disability attributable to his November 1983 injury, as it existed immediately prior to March 4, 1986, the date of claimant's "new injury."

Accordingly, the request for reconsideration is granted and our prior order withdrawn. The "extent of permanent

disability" issue is remanded to the Presiding Referee and, eventually, to the Hearings Referee, for further action consistent with this order. Otherwise, on reconsideration, as supplemented herein, the Board adheres to and republishes its former order, effective this date.

IT IS SO ORDERED.

LAWRENCE J. KAFORSKI, Claimant
J. Rion Bourgeois, Claimant's Attorney
Nancy Meserow, Defense Attorney
Miller, et al., Defense Attorneys

WCB 85-07144 & 85-15602
September 24, 1987
Order Denying Reconsideration

Wausau Insurance has requested reconsideration of the Board's Order on Review (Remanding) dated June 1, 1987. Based upon the record "as currently developed," we did not find claimant's carpal tunnel condition compensable. However, we remanded the case to the Referee for further development in light of claimant's post-hearing surgery. Contending that the treating surgeon has concluded that the visual inspection during the operation was of no assistance in determining the etiology of claimant's condition, Wausau asks that our prior order be reconsidered and held in abeyance.

The request is denied.

IT IS SO ORDERED.

STEVEN B. LUBITZ, Claimant
Vick & Gutzler, Claimant's Attorneys
Rankin, et al., Defense Attorneys

WCB TP-87009
September 24, 1987
Third Party Order

Claimant has petitioned the Board to resolve a dispute concerning a proposed settlement of a third party action. See ORS 656.587. Claimant and the third party have agreed to settle claimant's cause of action for $10,000. The paying agency's lien is presently $19,794.68. The agency contends that the third party's liability has been clearly established and that the record supports the full recovery of claimant's damages. Asserting that it opposes any settlement which does not fully satisfy its lien, the agency refuses to approve the current offer.

Pursuant to ORS 656.587, the Board is authorized to resolve disputes concerning the approval of any compromise of a third party action. In exercising this authority, we will approve settlements negotiated between a claimant/plaintiff and a third party defendant, unless the settlement amount appears to be grossly unreasonable. Virginia Merrill, 35 Van Natta 251 (1983); Rose Hestkind, 35 Van Natta 250 (1983).

Applying the aforementioned standard to the present record, we are not persuaded that the settlement offer is grossly unreasonable. Consequently, the settlement offer of $10,000 is approved. Furthermore, the proceeds of the settlement shall be distributed in accordance with ORS 656.593(1).

IT IS SO ORDERED.

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

Own Motion 86-0415M
September 24, 1987
Second Interim Own Motion Order
Referring Matter for Hearing

Claimant and Jeld-Wen, Inc., a self-insured employer, have requested reconsideration of the Board's September 3, 1987 Interim Own Motion Order. Pursuant to our order, the employer has been directed to pay interim compensation benefits, based on claimant's 1978 temporary total disability rate, commencing effective March 4, 1987 and continuing, less time worked, until claimant is released to regular work, returns to regular work, or his claim is closed pursuant to ORS 656.278.

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

The employer requests reconsideration. In the event that claimant is ultimately found not to be entitled to temporary disability benefits from either claim, the employer is concerned over the possibility of paying compensation that it may never be able to recover. Should claimant fail to receive future permanent disability awards resulting from his 1978 injury, we acknowledge that such an outcome theoretically exists. However, these concerns were fully considered before the issuance of our prior order. We found then, as we continue to find, that, under the present circumstances, the payment of interim compensation benefits pending the upcoming hearing is justified.

Finally, claimant has asked that we award an attorney fee for his counsel's services in procuring his interim compensation benefits. The request is granted. For efforts expended and results obtained in this matter, claimant's attorney is awarded 25 percent of the increased compensation made payable by our prior order, not to exceed $750. This fee is payable out of, rather than in addition to, claimant's compensation. OAR 438-47-070.

Accordingly, the requests for reconsideration are granted and our prior order is withdrawn. On reconsideration, as supplemented herein, we adhere to and republish our September 3, 1987 order, effective this date.

IT IS SO ORDERED.

CHARLES H. WHIDDON, Claimant
Pozzi, et al., Claimant's Attorneys
SAIF Corp Legal, Defense Attorney
Rankin, et al., Defense Attorneys

WCB 85-14106 & 85-14081
September 24, 1987
Order on Reconsideration

The self-insured employer has requested reconsideration of the Board's Order on Review dated May 19, 1987.

On June 16, 1987, we abated our prior order to consider the employer's request. On reconsideration, the employer asserts that in finding that claimant timely appealed its denial we have failed to follow our ruling in Margaret J. Sugden, 35 Van Natta 1251 (1983) and the recent Court of Appeals decision of Cowart v. SAIF, 86 Or App 748 (August 5, 1987). We disagree.

Since deciding Sugden, the Board promulgated OAR 438-05-065. This rule states that the denial shall be "delivered," not just sent. Thus, a returned and unclaimed denial sent certified mail does not satisfy this rule. Further, Sugden is factually distinguishable from this case. In Sugden, the insurer first sent the denial by certified mail. After it was returned unclaimed, the insurer sent it regular mail. The regular mail denial was sent to the correct address within the statutory time to appeal. The denial was not returned. The Board concluded that these mailings constituted sufficient notice.

Here, the employer made only the certified mailing of the denial within the statutory time for appeal. The denial was returned unclaimed. Thus, we know conclusively that no denial ever timely reached claimant. We are unwilling to conclude that a denial sent certified mail and returned unclaimed satisfies the notice requirement of ORS 656.319 or constitutes "delivery" as stated in OAR 438-05-065. Because of the significant factual differences, we need not decide if Sugden remains good law.

The employer also asserts that Cowart v. SAIF, supra. operates to bar claimant's claim as untimely. In Cowart, the court stated that "[t]he date of mailing, not receipt, starts the running of the 60 days." Importantly, however, the claimant in Cowart received the denial well before the expiration of the 60 days. Cowart did not lessen the insurer's obligation of notifying claimant pursuant to ORS 656.319.

The remaining issues raised in the employer's request have been adequately addressed in our prior order.

Therefore, the request for reconsideration is granted and our prior order withdrawn. On reconsideration, as supplemented herein, the Board adheres to and republishes its former order of May 19, 1987, effective this date

IT IS SO ORDERED.

MELVIN S. GUIDO, Claimant
Malagon & Moore, Claimant's Attorneys
Phillip L. Nyburg, Defense Attorney

WCB 86-12968
September 28, 1987
Second Order of Dismissal

Claimant has requested reconsideration of the Board's September 11, 1987 Order of Dismissal. Since the insurer withdrew its appeal of the Referee's order, its request for Board review was dismissed. Contending that he has raised additional issues in his respondent/cross-appellant's brief, claimant asks that we

consider his so-called "cross-appeal." We conclude that we lack jurisdiction to comply with claimant's request.

This issue was discussed in Jimmie Parkerson, 35 Van Natta 1247, 1250 (1983). We stated as follows:

> "The primary purpose for filing a cross-request for review is to maintain control over the Board's jurisdiction. A respondent who has failed to cross-request Board review and who raises an issue in its respondent's brief is at the mercy of an appellant who, upon recognizing the fact that a potentially meritorious argument has been raised in respondent's brief, or for any other reason, withdraws the request for Board review. If the respondent has cross-requested review, the Board would retain jurisdiction over the cross-request. If the respondent had not cross-requested review, there would be nothing to retain jurisdiction over and respondent would lose the opportunity to have the issue raised in its brief reviewed."

Here, claimant raised several issues in his respondent's brief. However, he did not timely file, formally or informally, a cross-request for Board review. See ORS 656.289(3). Consequently, upon the withdrawal of the insurer's request for review, we no longer have jurisdiction to consider the issues addressed in claimant's brief. See Jimmie Parkerson, supra.

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

BONNIE A. HEISLER, Claimant
E. Jay Perry, Defense Attorney

WCB 86-10481
September 28, 1987
Order Denying Motion to Dismiss

The insurer has moved the Board for an order dismissing claimant's request for review on the ground that she did not file a brief within the time allowed by the briefing schedule. Filing of briefs is not jurisdictional. OAR 438-11-015(1); Elmira K. Satcher, 38 Van Natta 557 (1986). Consequently, the insurer's motion is denied. Inasmuch as the insurer has chosen not to file a respondent's brief, the case shall now be docketed for review.

IT IS SO ORDERED.

RICHARD A. JOHNSON, Claimant
Doblie & Associates, Claimant's Attorneys
SAIF Corp Legal, Defense Attorney

WCB 84-00831
September 28, 1987
Order on Remand

This matter is before the Board on remand from the Court of Appeals. Johnson v. City of Roseburg, 86 Or App 344 (1987). Concluding that claimant's occupational disease claim for lung cancer is compensable, the court reversed our prior order that had upheld the SAIF Corporation's denial.

We have been instructed to reinstate the Referee's order, which found the claim compensable. Accordingly, pursuant to the court's mandate, the Referee's order is reinstated.

IT IS SO ORDERED.

WILLIAM L. STANART, Claimant
Jerry E. Gastineau, Claimant's Attorney
Cowling & Heysell, Defense Attorneys

WCB 86-05734
September 28, 1987
Order on Reconsideration

The insurer has requested reconsideration of that portion of the Board's Order on Review dated September 3, 1987, that awarded claimant a $150 attorney fee for prevailing on Board review. Since claimant did not timely submit a brief on review, the insurer contends that no attorney fee should have been awarded. We disagree.

We have previously held that ORS 656.382(2) provides for an insurer-paid attorney fee where claimant prevails over an insurer-initiated request for review. Myron W. Rencehausen, 39 Van Natta 56 (1987). Thus, we cannot deny the award of fees in the first instance. Charles D. Barney, 39 Van Natta 646 (July 14, 1987); Myron W. Rencehausen, supra. Yet, we have been delegated the authority to determine the amount of the fee. Myron W. Rencehausen, supra; Dan W. Hedrick, 38 Van Natta 208 (1986), aff'd mem 83 Or App 275 (1986). To assist us in determining the amount of a reasonable attorney fee, administrative rules have been promulgated. See OAR 438-47-000 et seq.

Here, as previously noted, claimant's brief was rejected as untimely. Thus, he was prohibited from responding to the insurer's contention that its partial denial relating to disc degeneration in claimant's low back should be upheld. However, since claimant has prevailed over an insurer-initiated appeal, he remains entitled to an insurer-paid attorney fee on Board review. See Myron W. Rencehausen, supra.

In determining claimant's attorney fee award, the aforementioned points and authorities were thoroughly considered. Upon further consideration, we continue to find that the award was appropriate. See Charles D. Barney, supra; Betty J. McMullen, 38 Van Natta 117 (1986).

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

IT IS SO ORDERED.

DANNY R. AKERS, Claimant
Roberts, et al., Defense Attorneys

WCB 86-11855
September 29, 1987
Second Order Denying Motion to Dismiss

The insurer has requested reconsideration of our August 21, 1987 order that denied its motion to dismiss claimant's request for Board review. The insurer reiterates its contention that claimant failed to timely mail copies of his request for review to the parties.

By hand delivery, claimant, who was then unrepresented,

timely filed his request for Board review on July 17, 1987, 29 days after the Referee's June 18, 1987 order. Included with this request, was claimant's representation that "I have sent copies to all the parties in concern." Directly below this representation were the names and addresses of the employer, its insurer, and the insurer's attorney.

The insurer's counsel admits that it received a copy of claimant's request. It further concedes that its staff failed to retain the envelope in which the copy of claimant's request was contained. Yet, since the copy was not acknowledged as received until July 27, 1987, ten days after the filing of the original request, the insurer contends that there is insufficient evidence to conclude that claimant perfected the Board's jurisdiction. Specifically, the insurer argues that claimant must produce a certified mail receipt showing the date copies of the request were mailed to the parties. We disagree.

Pursuant to ORS 656.295(2), copies of the request for Board review shall be mailed to all parties to the proceeding before the Referee. The copies shall be simultaneously mailed to all parties who appeared at the hearing and to their attorneys, if represented by an attorney. OAR 438-11-005(3). Anything delivered for filing before the Board shall include or have attached thereto either an acknowledgment of service by the person served or proof of service in the form of a certificate executed by the person who made service showing personal delivery or deposit in the mails together with the names and addresses of the persons served. OAR 438-11-035(2). However, an unrepresented injured worker is not expected to have familiarity with the Board's rules and shall not be held strictly accountable for failures to follow them. OAR 438-05-035.

As previously noted, the request for review included the then unrepresented claimant's statement that he had "sent copies to all parties in concern." Listed as "parties in concern" were the names and addresses of the employer, its insurer, and the insurer's attorney. Furthermore, the insurer's counsel acknowledges that it received a copy of the request, albeit some ten days after the original request was filed.

Following our further review of this matter, the record continues to establish that claimant timely mailed a copy of his request for Board review to all parties to the proceeding in compliance with statutory and administrative requirements. See ORS 656.295(2); OAR 438-11-005(3); 438-11-035(2)(b). Accordingly, upon reconsideration, we conclude that we have jurisdiction to consider claimant's request for Board review.

IT IS SO ORDERED.

DONALD G. ANDERSON, Claimant
Coons & Cole, Claimant's Attorneys
Cummins, Cummins, et al., Defense Attorneys

WCB 85-12803
September 29, 1987
Order on Review

Reviewed by Board Members Lewis and Ferris.

Claimant requests review of Referee Garaventa's order that upheld the self-insured employer's denial of claimant's occupational disease claim for his bilateral hand/wrist condition. Additionally, claimant argues that the Referee erred

in reopening the record post-hearing. In support of his argument, claimant requests that the Board take "administrative notice" and consider several correspondences that are not contained in the record. We interpret this request as a motion for remand. The issues are compensability, evidentiary, and remand.

A Referee has discretion to reopen a record either before an appeal is filed or, if no appeal is filed, before the appeal period expires. OAR 438-07-025(1). Here, following the hearing, the Referee determined that the record had been incompletely developed with respect to the effect of claimant's diabetes. Accordingly, the Referee reopened the record and allowed both parties to generate further medical evidence. Given the complex nature of claimant's hand/wrist condition, we do not consider the Referee's actions to be an abuse of discretion.

Turning to claimant's request for remand, we may remand to the Hearings Division should we find that the record has been "improperly, incompletely or otherwise insufficiently developed." ORS 656.295(5). Here, we find that the record concerning the Referee's reopening of the record post-hearing is properly and completely developed. Therefore, remand is not appropriate.

The Board affirms the order of the Referee.

ORDER

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

RICHARD W. GALLENTINE, Claimant
Royce, et al., Claimant's Attorneys
SAIF Corp Legal, Defense Attorney

WCB 85-04736
September 29, 1987
Order on Review

Reviewed by Board Members McMurdo and Lewis.

Claimant requests review of Referee Leahy's order that: (1) concluded that he lacked jurisdiction to consider the extent of claimant's scheduled and unscheduled permanent disability; and (2) forwarded the matter to the Board for consideration under its Own Motion authority. Claimant further requests that the Board remand this matter to the Hearings Division for a decision on the merits. The issues are jurisdiction, remand, and extent of scheduled and unscheduled permanent disability.

Claimant compensably injured his left hand in October 1972. In October 1975, a Determination Order closed his claim awarding 50 percent scheduled permanent disability. Claimant requested a hearing and was awarded an additional 25 percent by a 1976 Opinion and Order. In 1977, his claim was reopened and he underwent two surgeries. Claimant's aggravation rights expired in October 1980, while his claim was in open status.

In March and October 1981, two more Determination Orders issued, awarding temporary disability only. Claimant appealed and went to hearing before Referee Menashe in June 1982. At this 1982 hearing, claimant argued that his claim should be reopened for further medical treatment and temporary disability benefits. SAIF agreed to voluntarily reopen the claim under ORS 656.278(4). Referee Menashe found that claimant was entitled to further temporary disability benefits and ordered SAIF to reopen the claim.

Thereafter, SAIF submitted a 1503 form requesting that

the Evaluation Division close claimant's claim. In April 1984, a Determination Order issued awarding temporary disability only.

Claimant appealed the Determination Order and a hearing was held before Referee Leahy in July 1986. At the hearing, SAIF argued that the Hearings Division lacked jurisdiction to consider the extent of claimant's permanent disability. Referee Leahy deferred ruling on SAIF's dismissal motion and proceeded to hear the merits of claimant's case. After the hearing, the parties submitted written arguments on the jurisdictional question. After considering the matter, Referee Leahy concluded that the Hearings Division was without jurisdiction. Consequently, he "remanded the case to the Board for consideration under its Own Motion authority."

On review, SAIF argues that it "voluntarily reopened" claimant's claim pursuant to ORS 656.278(4) and, therefore, the only means of closing the claim was by the Board's Own Motion authority. According to SAIF, the April 1984 Determination Order should be viewed as "void" without appeal rights. We do not agree.

At the 1982 hearing, claimant sought claim reopening for additional temporary disability compensation. In his Opinion and Order, Referee Menashe stated:

> "SAIF has agreed to reopen the claim and pay temporary total disability compensation under ORS 656.278(4), an amendment to the Own Motion statute adopted in 1981. The parties differ concerning claimant's rights if the claim is reopened under this new statute, but that issue is premature at this time." (emphasis added).

Referee Menashe went on to consider whether to reopen claimant's claim, ultimately finding in favor of claimant. Thus, SAIF was directed to reopen the claim and pay temporary disability benefits pursuant to Referee Menashe's order.

If a claim is reopened, for whatever reason, during the time claimant still has the right to appeal from a Determination Order, the claim should subsequently be closed pursuant to ORS 656.268. Carter v. SAIF, 52 Or App 1027, 1032 (1981); Coombs v.SAIF, 39 Or App 293 (1979). Here, since the claim had been reopened within one year from the October 1981 Determination Order, claimant was entitled to claim closure by the Evaluation Division. See Carter v. SAIF, supra; Coombs v. SAIF; supra Roger A. Driggers, 35 Van Natta 1208 (1983); Eugene Muehlhauser, 35 Van Natta 705 (1983).

Accordingly, we reverse Referee Leahy's order that concluded the Hearings Division lacked jurisdiction to consider claimant's request for hearing from the April 1984 Determination Order.

We now turn to claimant's request for 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). Here, Referee Leahy admitted the parties' exhibits and heard testimony on the extent of claimant's permanent disability. We are persuaded that the record was properly developed and that remand is not necessary. Therefore, we proceed to rate claimant's permanent disability.

The criteria for rating the extent of scheduled permanent disability is the loss of use or function of claimant's left hand. ORS 656.214(2). We do not apply the Department's administrative rules governing extent of scheduled disability in a rigid mechanistic fashion, but rather as guidelines. See Harwell v. Argonaut Insurance Co., 296 Or 505 (1984); SAIF V. Baer, 61 Or App 335 (1983); Boyce v. Sambo's Restaurant, 44 Or App 305, 308 (1980).

Claimant has an award of 75 percent scheduled permanent disability. His left index finger was amputated shortly after his 1972 compensable injury. He has malrotation problems with his long finger. He testified that with overuse his left wrist "freezes up." He also stated that he can carry a bucket of water, but not lift weights with his left hand. In November 1985, Dr. Sandbulte, claimant's treating orthopedist, reported that claimant was able to use his left hand for lighter activities. Dr. Sandbulte advised claimant to continue using the hand. After conducting our de novo review of the lay and medical evidence, we consider the existing award of 75 percent scheduled permanent disability to adequately compensate claimant.

Lastly, we turn to the issue of unscheduled permanent disability. Claimant testified that he experienced pain up into the left shoulder. However, the first medical evidence of shoulder complaints is in Dr. Sandbulte's November 1985 chart notes. In January 1986, Sandbulte notes a "new complaint" of left shoulder pain. According to Sandbulte, claimant's left shoulder complaints began "four to five" years ago. Neither Sandbulte nor any other medical expert provides an opinion on the etiology of claimant's left shoulder complaints. Given the 13-year time span between claimant's compensable injury and his reporting of left shoulder complaints, and the lack of medical evidence regarding causation, we are not persuaded that the 1972 injury is a material contributing cause of claimant's left shoulder complaints. Accordingly, claimant is not entitled to an award of unscheduled disability.

ORDER

The Referee's order is reversed. The April 1984 Determination Order is affirmed.

GERALD GAMEZ, Claimant
Michael B. Dye, Claimant's Attorney
Schwabe, et al., Defense Attorneys

WCB 85-10457
September 29, 1987
Order on Review

Reviewed by Board Members McMurdo and Lewis.

Claimant requests review of that portion of Referee Howell's order that allowed the self-insured employer to reduce claimant's temporary total disability payments by amounts of unemployment compensation claimant had received during pertinent periods. Claimant has also filed a supplemental request for Board review regarding a letter from the Hearings Division's Presiding Referee, which found that the Division was without jurisdiction to consider the issue of payment of a medical expert's witness fee for testifying at the hearing. The issues are offset and jurisdiction.

We affirm the Referee's order. See Wells v. Pete Walker's Auto Body, 86 Or App 739 (1987). Furthermore, we dismiss

claimant's supplemental request for Board review for lack of subject matter jurisdiction.

ORDER

The Referee's order dated June 11, 1986 is affirmed. Claimant's supplemental request for Board review is dismissed.

MARK A. GRIFFITH, Claimant
Welch, et al., Claimant's Attorneys
SAIF Corp Legal, Defense Attorney

WCB 86-01001
September 29, 1987
Order on Review

Reviewed by Board Members Lewis and McMurdo.

Claimant requests review of Referee Podnar's order that upheld the SAIF Corporation's denial of his occupational disease claim for solvent induced encephalopathy. The issue is compensability.

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

As a prerequisite to compensation, claimant must establish that he suffered a compensable injury. Brown v. SAIF, 79 Or App 205 (1986). A nondisabling compensable injury is "an injury requiring medical services only." ORS 656.005(8)(c). Further, "[a]lthough the legislature enacted ORS 656.005(8)(c) to provide compensation for nondisabling injuries, we do not believe that it intended to provide compensation if claimant does not prove that he has suffered actual physical or mental harm." Brown at 209.

Here, claimant did have minimal exposure to organic solvents that potentially could cause encephalopathy. Dr. Morton, claimant's treating physician, opined that many of claimant's symptoms were related to his exposure to organic solvents and constituted encephalogy. However, Morton could not state that claimant's exposure had caused any brain damage. Furthermore, Dr. Bayer, toxicologist, concluded that claimant's minimal exposure to organic solvents had not caused encephalopathy or any of his symptoms. Like the Referee, we find the opinion of Dr. Bayer well reasoned and most persuasive. Consequently, we conclude that claimant has failed to establish that he has an existing condition that constitutes an injury within the meaning of ORS 656.005(8). Brown, supra.

ORDER

The Referee's order dated August 27, 1986 is affirmed.

DALE C. LEABO, Claimant
Pozzi, et al., Claimant's Attorneys
Moscato & Byerly, Defense Attorneys

WCB 86-02907
September 29, 1987
Order on Review

Reviewed by Board Members Lewis and Ferris.

The insurer requests review of Referee Galton's order that set aside its partial denial of claimant's left knee claim for osteoarthritis and varicose veins. The issue is compensability.

We agree with the Referee's finding of compensability. However, we disagree with the Referee's determination that the

insurer's partial denial was impermissable under Bauman v. SAIF, 295 Or 788 (1983).

Since the Referee's decision, the Supreme Court decided Johnson v. Spectra Physics, 303 Or 49 (1987). In Johnson, the Court stated that "an insurer's acceptance of a claim only includes those injuries or conditions specifically accepted in writing pursuant to ORS 656.262(6)." Id. at 58. Here, despite knowledge of claimant's preexisting left knee varicose veins and osteoarthritis, the insurer never specifically accepted those conditions. Consequently, the insurer's partial denial was not precluded by Bauman, supra.

However, at the time of its' partial denial, the insurer was still processing claimant's accepted left knee claim. Moreover, the claim had not been closed at the time of the partial denial. Consequently, we agree with the Referee that, prior to closure of the accepted knee claim pursuant to ORS 656.268(3), the insurer's denial was procedurally improper. See Maddocks v. Hyster Corporation, 68 Or App 372, rev den, 297 Or 601 (1984); Roller v. Weyerhaeuser, 67 Or App 583 amplified, 68 Or App 743 (1984). Because the denial was procedurally improper, it would be inappropriate for us to consider the compensability of the denied conditions.

We find this case to have been of average difficulty with an ordinary likelihood of success on Board review. A reasonable attorney fee is therefore awarded.

ORDER

The Referee's order dated October 1, 1986 is affirmed. Claimant's attorney is awarded $550 for services on Board review, to be paid by the insurer.

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

WCB 86-06429
September 29, 1987
Order on Review

Reviewed by Board Members McMurdo and Lewis.

Claimant requests review of Referee Leahy's order that: (1) declined to award additional scheduled permanent disability beyond the Determination Order's awards of 35 percent (52.5 degrees) permanent disability for her left knee condition and 45 percent (67.5 degrees) for her right knee condition; (2) upheld the insurer's denial of claimant's medical services claim for a jacuzzi and recliner chair; and (3) declined to assess penalties and attorney fees for allegedly improper claims processing. The issues are extent of scheduled permanent disability, medical services, penalties and attorney fees.

We affirm that portion of the Referee's order concerning the extent of permanent disability with the following comment.

In denying additional scheduled permanent disability the Referee relied on Nelson v. EBI Comapanies, 296 Or 246 (1984), and concluded that claimant had failed to mitigate the extent of her disability through weight loss. Determining that claimant must "exercise a will to reduce," the Referee concluded that claimant had made no concerted effort to lose weight. We disagree with this analysis. The insurer has the burden of proving that

claimant failed to make reasonable effort to follow medical advice to lose weight. Christenson v. Argonaut Insurance Co., 72 Or App 110 (1985). Following our de novo review of the medical and lay evidence, we conclude that the insurer has failed to carry its burden.

However, we conclude that claimant is not entitled to additional scheduled permanent disability. The only medical evidence rating claimant's loss of function from her knee injuries was provided by the Orthopaedic Consultants. The Consultants stated that her loss of function due to the compensable injuries was mildly moderate. Following our de novo review of the medical and lay evidence, we conclude that the Determination Order adequately compensated claimant for the loss of function resulting from her compensable knee injuries.

We reverse that portion of the Referee's order that upheld the insurer's denial of the jacuzzi and recliner chair.

In upholding the denial of claimant's request for a jacuzzi and recliner chair, the Referee concluded that the reports of Dr. Gripekoven failed to satisfy the requirements of OAR 436-10-040(7). We disagree.

In material part OAR 436-10-040(7) states:

> "Furniture is not a medical service. Articles such as beds, hot tubs, chairs, jacuzzis, and gravity traction devices are not compensable unless a need is clearly justified by a report which establishes that the 'nature of the injury and the process of recovery requires' that the item be furnished. The report must set forth with particularity why the patient requires an item not usually considered necessary in the great majority of workers with similar impairments."

In February 1986 Dr. Gripekoven stated that claimant needed regular hydrotherapy and a recliner chair, as she had difficulty with ambulation and increased symptoms after returning to work. To that end, Gripekoven prescribed a home jacuzzi and recliner chair. In October 1986 Dr. Gripekoven again prescribed the jacuzzi and chair to speed claimant's recovery and aid with mobilization and ambulation. He noted that claimant's weight in conjunction with the knee injuries had produced impairment beyond that expected in the majority of workers with simple chondromalacia. We conclude that the combination of these reports satifies the requirements of OAR 436-10-040(7). Therefore, we hold that the jacuzzi and recliner chair are compensable.

ORDER

The Referee's order dated November 4, 1986 is reversed in part and affirmed in part. The insurer's denial of claimant's medical services claim for a jacuzzi and recliner chair is set aside. The insurer is directed to process the claim according to law. The remainder of the order is affirmed. For services at the hearings level and on Board review concerning the medical services issue, claimant is awarded $800, to be paid by the insurer.

PAMELLA K. PRUETT, Claimant
Charles D. Maier, Claimant's Attorney
Acker, Underwood, et al., Defense Attorneys

WCB 86-12085
September 29, 1987
Order on Review

Reviewed by Board Members McMurdo and Lewis.

The insurer requests review of that portion of Referee Baker's order that awarded claimant 35 percent (112 degrees) unscheduled permanent disability for a low back, neck and left shoulder injury, in lieu of a Determination Order that awarded no permanent disability. In her brief, claimant requests review of that portion of the Referee's order that found that her claim was not prematurely closed by the Determination Order dated August 25, 1986. On review, the issues are premature closure and extent of scheduled permanent disability.

We affirm that portion of the Referee's order that found that the claim was not prematurely closed. However, we find that claimant's award of permanent disability should be reduced. Consequently, we modify that portion of the Referee's order.

Claimant is a certified nurse assistant. She suffered a compensable injury on October 10, 1985, while lifting a heavy, combative patient by herself. Claimant experienced immediate pain in her low back, neck and left shoulder. She initially sought treatment from Dr. Marshall and his associate, Dr. Dawson, both chiropractic physicians. Drs. Marshall and Dawson diagnosed acute traumatic cervical and left deltoid strain, as well as lumbosacral tropism with attending strain. Although they restricted claimant to light work, she returned to her regular work as a nurse assistant and temporarily exacerbated her injury. On January 22, 1986, Dr. Dawson released claimant as medically stationary without permanent impairment.

In January 1986, claimant discontinued treatment with Dr. Dawson and began treating with Dr. Melgard, a neurosurgeon, and Dr. Tiley, an orthopedist. Dr. Melgard diagnosed probable acute and chronic lumbar strain and admitted claimant to the hospital for traction. In March 1986 Dr. Tiley diagnosed low back strain superimposed
on mild congenital problems, including disc degeneration, facet assymetry and lumbosacral scoliosis. Dr. Tiley found no neurological abnormalities and attributed claimant's neck pain to tension.

Later in March 1986, claimant discontinued treatment with Drs. Melgard and Tiley and began treating with Dr. Arden, a chiropractic physician. Dr. Arden diagnosed severe lumbosacral strain, a torn interosseous ligament fiber at the left sacroiliac joint, muscle spasms and edema. He rated claimant's impairment as moderate and began treating her with chiropractic manipulation and physiotherapy two to three times a week.

In June 1986, Independent Chiropractic Consultants examined claimant. They found no neurological abnormalities or radicular symptoms and noted that claimant displayed no characteristics suggestive of either acute or chronic pain or discomfort about the areas of complaint. The Consultants diagnosed cervical/thoracic strain and lumbar strain by history and found claimant medically stationary without permanent impairment. They recommended a weight loss program and a return

to work on a graduated basis over 30 days. Dr. Tiley concurred in their opinion, based on his March 1986 examination.

Dr. Arden reexamined claimant and disagreed with the Consultants' findings. He observed visual swelling in the lumbar region, pain on palpatation, 20 percent loss in low back range of motion, and positive Kemp's and Minor's signs. Dr. Arden diagnosed chronic neurospinal compression syndrome at L5-S1, chronic lumbosacral strain with myalgia, muscle spasms, and sciatica, and chronic cervical-thoracic strain. He stated that claimant was moderately impaired as a result of her occupational injury.

A Determination Order issued on August 26, 1986 and awarded no permanent disability. On November 25, 1986, Dr. Arden further increased claimant's impairment rating to moderately severe. He also opined that she could not return to work as a nurse assistant and could do no repetitive bending, no lifting over 30 pounds, and no twisting while carrying weight.

Claimant testified to continued pain in her back, hips, legs and left hand, occasional loss of function in her arms, loss of motion in the neck and shoulder, limping "much of the time", headaches "all of the time", inability to tolerate standing on both legs, bending or lifting, and inability to tolerate prolonged sitting, standing or walking. The Referee found that claimant testified in a sincere and credible manner, and he believed that her symptoms were real to her, whether or not verified on a strictly objective organic basis.

At the time of hearing, claimant was 35 years old with an 11th grade education. She is a certified nurse assistant and has also worked as a secretary, beautician, cook and cannery laborer. With the exception of her initial unsuccessful return to her nursing duties, claimant has not sought work since her injury.

The Referee found that claimant was permanently impaired, based on her credible testimony and the opinion of her treating physician, Dr. Arden. Concluding that claimant had suffered a substantial loss of earning capacity, the Referee awarded 35 percent unscheduled permanent disability.

We agree with the Referee that claimant's disabling pain and physical limitations have left her with some permanent loss of earning capacity. ORS 656.214(5). However, we consider the Referee's award to be excessive.

In rating the extent of claimant's permanent disability, we consider her physical impairment from her compensable injury, including her credible lay testimony concerning her disabling pain and permanent limitations, 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., 50 Or App 260 (1982). Following our de novo review of the medical and lay evidence, and considering the aforementioned guidelines, we conclude that a 5 percent (16 degrees) unscheduled permanent disability award adequately compensates claimant for her back, neck and left shoulder injuries.

ORDER

The Referee's order dated December 23, 1986 is modified and affirmed. In lieu of the Referee's award and in addition to Determination Order's award of no permanent disability, claimant is awarded 5 percent (16 degrees) unscheduled permanent disability for her back, neck and left shoulder injuries, which is her total award to date. Claimant's attorney fee is adjusted accordingly. The remainder of the Referee's order is affirmed.

MONTE G. ROBBINS, Claimant
Kenneth D. Peterson, Claimant's Attorney
Roberts, et al., Defense Attorneys
Schwabe, et al., Defense Attorneys

WCB 85-09237 & 85-06722
September 29, 1987
Order on Reconsideration

EBI Companies has requested reconsideration of our Order on Review dated September 3, 1987. It states that the Board's action in reinstating its aggravation denial "created an overpayment" and requests that the Board authorize it to offset this overpayment against any future compensation payable on this claim. The overpayment to which EBI apparently refers is t e temporary disability compensation it presumably paid claimant on his claim for aggravation after the Referee set aside its denial. Although we later reinstated the denial and thus concluded that such compensation should not have been ordered paid, compensation paid in accordance with a Referee's order is not recoverable by way of offset. See ORS 656.313(2); Hutchinson v. Louisiana-Pacific Corp., 67 Or App 577, 581, rev den 297 Or 340 (1984). EBI's request for authorization for an offset, therefore, is denied.

Accordingly, the request for reconsideration is granted and our prior order withdrawn. As supplemented by this order, the Board adheres to and republishes its prior order, effective this date.

IT IS SO ORDERED.

MAX S. SWANBERG, Claimant
Malagon & Moore, Claimant's Attorneys
SAIF Corp Legal (Eugene), Defense Attorney

WCB 85-12935
September 29, 1987
Order on Review

Reviewed by Board Members Lewis and McMurdo.

Claimant requests review of Referee Seymour's order that: (1) declined to grant permanent total disability; and (2) awarded scheduled permanent disability of 20 percent (30 degrees) in addition to the 30 percent (45 degrees) awarded by a Determination Order for the loss of use or function of the left leg. On review, claimant contends that he is permanently and totally disabled. We agree and reverse.

Claimant is a 63-year old man, whose preinjury work experience consists of heavy labor. He has a high school education and has worked in a lumber mill operating edger and joiner machines since 1958. In November 1983 he filed a claim alleging that his work activities worsened a preexisting arthritic left knee condition. The claim was ultimately found compensable.

In October 1984 Dr. Bert performed a total left knee replacement. In March 1985 Dr. Bert stated claimant could perform

only sedentary work. Yet, at claimant's closing examination in September 1985, Dr. Bert stated that claimant was completely disabled from all usual and customary work. Shortly thereafter, Dr. Bert reported that claimant has "permanent partial impairment based on the total knee replacement, residual pain but has very little loss of motion."

In March 1986 Dr. Bert noted that claimant should not return to his usual and customary work and that he was fit for "very, very light work." Finally Dr. Bert concluded that because of his age, training and knee condition, claimant was permanently and totally disabled.

Mr. Niblack, claimant's vocational counselor, reported that claimant's only transferable skills as of March 1985 were those of an edger or joiner in a plywood mill. However, due to claimant's physical limitations, there were no suitable positions available at his former employer's mill. In July 1985, vocational assistance was terminated because additional surgery on claimant's left knee was anticipated.

Mr. Demers, a vocational consultant, reviewed claimant's medical records and conducted one interview with claimant in June 1986. Demers found that claimant had no available work skills within his present limits and that it would take two years to train him for sedentary work. Furthermore, Demers reported that claimant has no sedentary skills, cannot stand or sit for more than approximately one hour and can walk only on a level surface. In Demers' opinion, claimant is not now, nor will he be in the foreseeable future, a candidate for competitive employment. Although claimant has been unsuccessful in securing either full or part-time employment, he has looked for work in bulb fields and done odd jobs for a neighbor.

Claimant testified that he can stand approximately 30 minutes at a time and walk on level ground for short periods. He is unable to sit or stand for more than one hour and is prohibited from crouching, kneeling and climbing a ladder.

Claimant's other treating physician is Dr. Samuel, chiropractor. In July 1986, Dr. Samuel stated that he felt claimant to be permanently and totally disabled because of his total left knee replacement. The Referee dismissed Dr. Samuel's opinion concerning claimant's condition because Dr. Samuel had not seen claimant since July 1984. However, Dr. Samuel testified that his opinion was based on the medical records provided by Dr. Bert, as well as his knowledge of claimant whom he has periodically treated since 1969.

The Referee was persuaded that claimant could not return to his regular work. However, the Referee found that claimant was not entitled to an award of permanent total disability. We disagree.

Dr. Bert and Dr. Samuel agree that claimant is permanently and totally disabled. Mr. Niblack reported that claimant's only skills were as an edger and joiner in mills, which were jobs that exceeded claimant's physical limitations. Mr. Demers reported that claimant has no sedentary skills, cannot stand or sit for a sustained period of time and, because of his physical limitations, is not a candidate for competitive employment.

Claimant does not exhibit total physical incapacity. Thus, he can be considered permanently and totally disabled only if he falls within the "odd-lot" doctrine. See Clark v. Boise Cascade Corp., 72 Or App 397, 399 (1985). We find that claimant satisfies the requirements of this doctrine. The medical evidence establishes that claimant is fit only for sedentary work. Yet, the preponderence of the evidence available at the time of hearing persuasively indicates that considering claimant's education, age and lack of transferable skills, he is currently incapable of performing regular work activities within these physical restrictions. See Gettman v. SAIF, 289 Or. 609, 616 P2d 437 (1980). Furthermore, claimant has demonstrated he was willing to seek regular gainful employment and has made reasonable efforts to obtain such employment. See ORS 656.206(3); Wilson v. Weyerhauser, 30 Or App 403 (1977); Smith v. Brooks-Scanlon, 54 Or App 730 (1981). Consequently, we conclude that he is permanently and totally disabled within the meaning of ORS 656.206.

Finally, we find that the claimant was permanently totally disabled as of July 31, 1986, the date of hearing. The SAIF Corporation is authorized to offset against the permanent total disability benefits due, any permanent partial disability benefits paid subsequent to July 31, 1986.

ORDER

The Referee's order dated January 8, 1987 is reversed. Claimant is granted permanent total disability as of July 31, 1986. Claimant's attorney is awarded 25 percent of the increased compensation created by this order. However, the total of fees allowed by the Referee and the Board shall not exceed $3,000.

WAYNE W. WITTROCK, Claimant
Michael B. Dye, Claimant's Attorney
Schwabe, et al., Defense Attorneys

WCB 84-08993
September 29, 1987
Order on Review

Reviewed by Board Members Lewis and McMurdo.

Claimant requests review of those portions of Referee Seymour's order that: (1) declined to direct the insurer to repay offset temporary disability benefits totalling $1,615.55; and (2) declined to assess penalties and attorney fees for the insurer's alleged unreasonable offset. The issues are repayment of the offset and penalties and attorney fees.

Claimant sustained a compensable right shoulder injury in February 1983. His claim was closed by a Determination Order and then reopened for surgery in July 1985. While his claim was still in open status, claimant requested a hearing raising the issue of improper calculation of his temporary disability benefits. Shortly thereafter, the insurer submitted a 1503 form requesting the Evaluation Division to close claimant's claim. The form neither requested permission for an offset nor raised any question concerning the proper rate of claimant's temporary disability payments. In July 1986, a new Determination Order issued, awarding temporary and permanent disability. The Determination Order contained the following typewritten statement: "DEDUCTION OF OVERPAID TEMPORARY DISABILITY, IF ANY, FROM UNPAID PERMANENT DISABILITY IS APPROVED."

After the Determination Order issued, the insurer determined that it had paid temporary disability at an excessive

rate and beyond the date claimant became medically stationary. Concluding that it was entitled to an overpayment of temporary disability equalling $1,995.12, the insurer deducted that amount from claimant's award of permanent partial disability.

The Referee agreed that the insurer had overpaid temporary disability benefits. Based on the Determination Order's authorization for an offset, the Referee concluded that the insurer had acted properly in reducing claimant's permanent disability benefits. We disagree.

In Forney v. Western States Plywood, 66 Or App 157, 160 (1983), aff'd, 297 Or 628 (1984), the court held that an insurer may not reduce a claimant's benefits without "prior authorization" from the Evaluation Division, Referee or the Board. Here, we are confronted with the question of whether the Determination Order granted "prior authorization" for the insurer's reduction of claimant's permanent disability benefits. Claimant concedes that the Determination Order authorized the insurer to offset $379.57 in temporary disability benefits paid between the date he became medically stationary and the issuance of the Determination Order. However, he argues that the insurer was without authority to reduce his permanent disability benefits by $1,615.55, due to its incorrect calculation of his temporary disability benefits.

At the time the insurer requested claim closure, it had not discovered its error in calculating claimant's proper rate of temporary disability benefits. Indeed, it is uncontroverted that the insurer did not discover its miscalculation until approximately one month after the issuance of the Determination Order. Therefore, we believe that the Evaluation Division could not have granted "prior authorization," as required by Forney, supra.

We understand the Determination Order's "prior authorization" to apply solely to the $379.57. The insurer indicated on the 1503 form that it was continuing to pay claimant's temporary disability benefits. Thus, unlike the $1,615.55 overpayment resulting from the insurer's incorrect calculation of claimant's temporary disability benefits, the Evaluation Division had prior knowledge that an overpayment would result from the insurer's continued payments of temporary disability through the date of the Determination Order.

Next, we consider whether the insurer's offset was unreasonable for the purposes of penalties and attorney fees. ORS 656.262(10). Although the Determination Order authorized an offset, the insurer knew that it had not submitted any information to the Evaluation Division regarding its miscalculation of claimant's temporary disability payments. Moreover, the Forney court had previously enunciated the proper procedure for the insurer to follow:

> "If for example, an employer should discover an overpayment after a determination has become final, but while future compensation, subject to reduction, is owed, the employer may request a hearing pursuant to ORS 656.325(6) * * * *."

Here, the insurer did not apprise the Evaluation Division of its miscalculation of claimant's temporary disability benefits. Upon discovering what it considered an overpayment, the

insurer did not request a hearing. Rather, it proceeded to reduce claimant's award of permanent disability. We believe, therefore, that the insurer acted unreasonably and that penalties and attorney fees are warranted. ORS 656.263(10).

The record establishes that the insurer's miscalculation of claimant's temporary disability benefits resulted in an overpayment. Therefore, the insurer is hereby authorized to offset the $1,615.55 in overpaid temporary disability compensation against any future permanent disability compensation awarded for this claim. See Forney, 66 Or App at 159-60; Donald D. Mills, 37 Van Natta 219, 220 (1985).

ORDER

The Referee's order is reversed in part, and affirmed in part. That portion of the Referee's order that declined to direct repayment of the benefits withheld by the insurer is reversed. The insurer is ordered to repay $1,615.55 of the withheld benefits. The insurer is authorized to offset the overpayment created by this order against future permanent disability compensation that may be awarded on this claim. Claimant's attorney is awarded a reasonable attorney fee of 25 percent of the increased compensation granted by this order, not to exceed $750. This attorney fee shall be paid out of claimant's compensation. In addition, the insurer is ordered to pay claimant a penalty equal to 15 percent of the $1,615.55. Likewise, the insurer is ordered to pay claimant's attorney a reasonable attorney fee of $200 concerning this penalty issue. All remaining portions of the Referee's order are affirmed.

DAVID M. LINDAMOOD, Claimant
Malagon & Moore, Claimant's Attorneys
SAIF Corp Legal (Eugene), Defense Attorney

WCB 82-04069
September 30, 1987
Order on Review

Reviewed by Board Members Ferris and Lewis.

The SAIF Corporation requests review of Referee Quillinan's order that set aside a disputed claim settlement relating to claimant's left knee and of that portion of Referee Nichols' order that set aside its denial of claimant's left knee condition. Claimant cross-requests reivew of that portion of Referee Nichols' order authorizing SAIF to offset the amount of the disputed claim settlement against any future compensation payable in connection with the knee condition. The issues are the disputed claim settlement, t e compensability of claimant's left knee condition and the propriety of the offset.

The Board reverses Referee Quillinan's order and reinstates the disputed claim settlement for the reasons previously stated in David M. Lindamood, 36 Van Natta 1678 (1983). Given this result, the issues decided by Referee Nichols are moot and her order will also be reversed.

ORDER

Referee Quillinan's order dated October 18, 1983, as amended by the order dated November 7, 1983, and Referee Nichols' order dated October 6, 1986 are reversed. The disputed April 27, 1982 claim settlement is reinstated and affirmed.

LYRIS J. REAM, Claimant
Pozzi, Wilson, et al., Claimant's Attorneys
SAIF Corp Legal (Portland West), Defense Attorney

WCB 85-06477
September 30, 1987
Order on Review

Reviewed by Board Members McMurdo and Lewis.

Claimant requests review of Presiding Referee Daughtry's order that dismissed her request for hearing. Some of the materials claimant submits on review are not otherwise in the hearing record. We treat the presentation of these materials as a request for remand. See Judy A. Britton, 37 Van Natta 1262 (1985). On review, the issues are remand and whether claimant has established good cause for failing to timely respond to the Presiding Referee's Order to Show Cause.

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 additional evidence presented in claimant's brief was obtainable with due diligence during the time the Referee's Order to Show Cause was outstanding. Accordingly, we find that remand is not warranted.

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

ORDER

The Referee's order dated December 30, 1986 is affirmed.

BETTY A. WILCOX, Claimant
Huffman, et al., Claimant's Attorneys
Rankin, et al., Defense Attorneys

WCB 86-00751
September 30, 1987
Order on Review

Reviewed by Board Members Ferris and McMurdo.

The self-insured employer requests review of Referee Pferdner's order that set aside its denial of claimant's occupational disease claim for depression. The issue is compensability.

Claimant, 33 years of age at the time of hearing, began working for the employer as a diffusion operator in March 1980. Within six months, she received two positive performance reviews and a promotion to "B" operator. In August 1981, her marriage was dissolved and she was ordered to pay $75 per month in child support. Over the next year and a half, she continued to receive positive performance reviews and was promoted to lead diffusion operator.

In 1983, claimant began working under a new supervisor, Mr. Downing. Downing reviewed claimant's work in August 1983, stating, inter alia:

> "You create a very positive environment to work in and communicate well with the various support groups. You work well as a team member while at the same time

> providing direction and leadership to your peers. Your assistance to me over the past two months, and your input into the quality assesment [sic] form has been invaluable. You are exceptionally responsible and dependable."

In September 1983, claimant was apparently $300 in arrears with her child support payments. Consequently, she was served with a garnishment order requiring her employer to withhold 25 percent of her wages.

In February 1984, claimant's ex-husband filed two court motions. First, a motion for modification of claimant's child support payments and visitation rights. The ex-husband sought to increase claimant's support payments from $75 to $400 per month. Second, a motion for production of documents seeking financial information from claimant. That same month, claimant's quality performance rating was dropped to "meets requireme-ts." Although Downing noted that claimant had made several mistakes over the last six months, he commended her for showing good leadership and hard work.

In July 1984, claimant received a court order increasing her child support payments to $250 per month. Shortly thereafter, she was served with another garnishment order. The order indicated that claimant was $700 in arrears with her child support payments.

In August 1984, claimant's quality rating was improved to "exceeds requirements" and Downing commented:

> "[Y]ou have done a tremendous job in the past six months of improving your organizational ability, the delegation of responsibility and focusing on improving the manner in which the area runs. You have performed admirably under some unusual situations and have been a very valuable asset to to [sic] both myself and the area as a whole."

Sometime between August 1^84 and March 1985, claimant was promoted to a Die Production Operator Specialist. In March 1985, her overall performance rating was dropped two grade levels. As a result, claimant's wage was increased only 10¢ an hour, rather than 30¢. In the performance review report, Downing noted that claimant needed improvement in the following areas: (1) delegation of responsibility; (2) tardiness; (3) organization; (4) attention to detail; and (5) communication with co-workers. Downing concluded the report by stating:

> "[Y]ou have done a very good job of improving the overall quality and quantity of the area during the last six months in very specific and quantifiable terms. You have demonstrated your ability to problem solve and come up with creative ways to improve . . . productivity and organization. You have proven your abilities as an operator specialist and have put forth an exceptional amount of effort."

Shortly thereafter, claimant accidentally touched an exposed wire. She testified that two holes were burned into her hand. The employer disputed that two holes were burned into claimant's hand, but conceded that there was an incident, that claimant received an electric shock, that two holes were burned through her double set of gloves, and that she sustained "thermal burns."

In July 1985, claimant was scheduled to have a review meeting with Downing. Fearing that the meeting would upset her, claimant desired to meet with Downing at the end of her shift. When this was not permitted, she became upset and left work.

A few days after claimant left work, she was examined by Dr. Cox, internist. Cox noted that claimant had "been under a lot of stress at work." He noted that claimant had been "markedly depressed" and that she felt "pressure from [her] boss." In September 1985, claimant began psychotherapy treatments under Dr. True, her treating psychologist. According to True, claimant's depression was directly related to her difficulties at work. In October 1985, Dr. Parvaresh, psychiatrist, examined claimant. Parvaresh felt that if claimant's stress was real, rather than perceived, then "the remaining steps all can easily be considered favorable to [claimant's] case." However, Parvaresh also noted that the stressful conditions contributing to claimant's depression were not unique to her employment.

In September 1986, claimant was examined by Dr. Hayes, psychiatrist. Hayes diagnosed, "Adjustment Reaction With Emotional Features, including those of anxiety and depression." According to Hayes, claimant was suffering from an underlying passive-aggressive personality disorder, which was the major contributing cause of her adjustment reaction. At the hearing, Hayes explained the etiology of claimant's adjustment reaction:

> "The major contributing factor, in my opinion, was the personality disorder, and I believe -- you know, ball park, I'd say the on-the-job contribution was no more than 15, 10 percent in truth."

Claimant testified to financial problems during 1985. In February 1985, she was apparently sued by Wood Creek Apartments for unpaid rent. In July 1985, J. C. Penney Company filed a collections suit. Claimant also admitted that she had been unable to repay a loan from Avco Financial Services and was consequently sued.

Finding the opinions of Drs. True and Parvaresh persuasive, the Referee concluded that claimant had proven an occupatonal stress claim. We disagree.

In order to establish the compensability of a mental disorder, claimant must prove that: (1) the real events or conditions of her work, when viewed objectively, were capable of producing stress; and (2) the conditions of her employment, when compared to nonemployment conditions, were the major co-tributing cause of her mental disorder. McGarrah v. SAIF, 296 Or 145 (1983); Leary v. Pacific Northwest Bell, 67 Or App 766 (1984). The stressful conditions must be objective in that they must be real, however, the medical effect on the worker is measured by the worker's actual reaction, rather than by an objective standard of

whether the conditions would have caused disability in the average worker. Petersen v. SAIF, 78 Or App 167, 170 (1986).

Claimant alleges that the following work related conditions caused her depression: (1) added responsibility resulting from her promotion to Die Production Operator Specialist after August 1984; (2) "differences of opinion" and "problems" with Downing, which worsened after March 1985; (3) an unfavorable performance review in March 1985; and (4) an on-the-job electrical shock incident in March or April 1985.

Here, the record reflects the existence of several stressful nonemployment conditions after August 1984. First, claimant's marital difficulties and chronic tardiness at work. Second, claimant was unable to pay her rent and was sued by her landlord in February 1985. Third, a collections suit was filed against her in July 1985. Last, claimant frequently missed work to deal with her domestic problems and was warned of her increasing absenteeism in March 1985.

According to Dr. Hayes, the aforementioned nonemployment stressors played an important role in causing claimant's depression:

> "The list of her off-the-job stressors is very significant and would likely cause an Adjustment Reaction With Mixed Emotional Features in most of us."

Similarly, Dr. Parvaresh stated:

> "[T]he kinds of problems [claimant] essentially ran into are not so unique to her workplace in that she obviously has had similar problems off the job, that is difficulty she began to have with her parents, subsequently in her marriage and her children and eventually in terms of having friends, getting along with people and having social support group[s]."

We generally accord greater weight to the opinion of the treating physician, absent persuasive reasons to do otherwise. Weiland v. SAIF, 64 Or App 810 (1983). Following our review of the record, we do not find Dr. True's opinion as persuasive as that of Dr. Hayes'. Hayes was the only medical expert to testify, and we find his explanations concerning the cause of claimant's disorder well reasoned. Unlike Hayes, Dr True does not address the causal effect of claimant's nonemployment stressors. In fact, none of True's reports record any history of claimant's nonemployment stressors. Dr. Parvaresh, on the other hand, did record a history of nonemployment stressors and found that claimant's stress was not unique to her employment. Dr. Cox does not render an opinion concerning the etiology of claimant's depression. We are persuaded by the opinion of Dr. Hayes. Somers v. SAIF, 77 Or App 259, 263 (1986).

After our de novo review of the lay and medical evidence, we are not persuaded that the employment conditions, when compared to nonemployment conditions, were the major contributing cause of claimant's depression.

ORDER

The Referee's order dated October 23, 1986 is reversed. The self-insured employer's denial is reinstated.

LOUIS J. SCHWARTZENBERGER, Claimant
Welch, Bruun & Green, Claimant's Attorneys
David O. Horne, Defense Attorney

WCB 85-02190
August 17, 1987
Order of Abatement

Claimant has requested that we abate our Order on Reconsideration dated July 30, 1987. In that Order, we granted the insurer's request for reconsideration on the issue of attorney fees. Claimant has now informed us that he was not notified of the insurer's request for reconsideration of our July 8, 1987 Order on Review until he received the Order on Reconsideration.

Claimant's request is granted and we abate our July 30, 1987 Order on Reconsideration. The insurer is ordered to provide claimant with a copy of its request for reconsideration. Claimant shall have 21 days from the receipt of that copy in which to respond.

IT IS SO ORDERED.

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

WCB 86-02856
September 28, 1987
Order of Abatement

Reviewed by Board Members Lewis and McMurdo.

Liberty Northwest Insurance Corporation has requested reconsideration of our Order on Review dated August 31, 1987. In order to allow sufficient time for claimant to reply to the request and for the Board to consider it, the Order on Review is withdrawn and abated. Claimant is allowed 14 days from the date of this order in which to file a reply.

IT IS SO ORDERED.

WORKERS' COMPENSATION CASES

Decided in the Oregon Supreme Court:

Decided in the Oregon Court of Appeals:

IN THE COURT OF APPEALS OF THE
STATE OF OREGON

In the Matter of the Compensation of
Shelli S. Jordan, Claimant.

JORDAN,
Petitioner,

v.

SAIF CORPORATION et al,
Respondents.

(WCB 84-10417; CA A39377)

Judicial Review from Workers' Compensation Board.

Argued and submitted January 23, 1987.

Merrill Schneider, Portland, argued the cause for petitioner. On the brief were Kathryn J. Harte and Merrill Schneider & Associates, Portland.

Darrell E. Bewley, Assistant Attorney General, Salem, argued the cause for respondents. On the brief were Dave Frohnmayer, Attorney General, Virginia L. Linder, Solicitor General, and Keith L. Kutler, Assistant Attorney General, Salem.

Before Buttler, Presiding Judge, and Joseph,* Chief Judge, and Warren, Judge.

BUTTLER, P. J.

Reversed and remanded.

---

* Joseph, C. J., *vice* Young, J.

BUTTLER, P. J.

Claimant seeks reversal of a Workers' Compensation Board order holding that medical treatment of her mild carpal tunnel syndrome is not compensable. On *de novo* review, we reverse and remand.

Claimant first began to feel pain in her wrist in September, 1980, when she was working part time as a furniture builder. She testified that the repeated use of a rubber mallet in hammering boards together caused pain. The doctor who examined claimant at that time diagnosed carpal tunnel syndrome and synovitis. Dr. Robertson, whom claimant began seeing immediately thereafter, also diagnosed carpal tunnel syndrome. Dr. Norton, an orthopedic consultant for SAIF, agreed that the type of work claimant had been doing could bring on carpal tunnel syndrome. Neurological stimulation studies did not confirm that diagnosis, presumably, as one doctor reported, because claimant's symptoms are so mild. Robertson released claimant for regular work on December 5, 1980, and by a determination order of February 19, 1981, she received an award of temporary total disability. However, she continued to experience symptoms of pain, swelling and numbness.

Dr. Stolzberg, a neurologist, examined claimant for SAIF in June, 1981, and found no objective basis for her continued complaints. He found her to be "completely normal" and disputed Robertson's diagnosis of carpal tunnel syndrome. In Stolzberg's opinion, claimant had experienced no more than a mild strain, which had resolved. He attributed her continued complaints to a manipulative personality, which allegedly makes her try to control her environment by complaining of "invisible" injuries. After Stolzberg's examination, claimant did not consult a doctor until March, 1984, when she returned to Robertson with complaints of wrist pain, swelling and numbness. At that time, she was seven months pregnant. His notes indicate that he believed that the wrist condition would disappear after her pregnancy terminated.

Dr. Reilly, a neurological consultant for SAIF, examined Robertson's chart notes and claimant's medical file in August, 1984. He agreed with Robertson that claimant was experiencing symptoms of mild carpal tunnel syndrome. By that time, her pregnancy had terminated but the wrist pain

had not. Reilly did not note that as a significant point; he stated only that wrist problems are common during pregnancy and that claimant's wrist condition was related to the pregnancy and not to the work injury of 1980.

SAIF denied the claim for medical treatment, stating that there was no evidence that the current wrist condition was related to the 1980 injury. At the hearing, claimant testified that her symptoms have been constant since the injury, but that between June, 1981, and March, 1984, she attempted to take care of the problem by using an ace bandage. She stated that she returned to Robertson in March, 1984, because the wrist was still symptomatic and she felt that it was time to have it reexamined. She stated that the wrist did not improve after pregnancy. Robertson wrote a report in June, 1985, stating that claimant's symptoms are related to the work injury, because they are identical to those experienced after the injury.

The referee agreed with SAIF that claimant's present wrist condition is related to her pregnancy. In addition to the opinion of Reilly, the referee relied in part on Stolzberg's finding that claimant's condition in 1981 was "completely normal" and that she had no permanent residuals of the injury. He also cited the fact that claimant had not sought medical treatment between 1981 and 1984, apparently viewing that as an indication that the injury had resolved in 1981. The Board affirmed, adopting the referee's opinion.

The medical treatment is compensable if the injury of 1980 continues to be a material contributing cause of the wrist condition. ORS 656.245; *see Taylor v. SAIF*, 75 Or App 583, 706 P2d 1023 (1985). Irrespective of Stolzberg's skepticism, claimant's testimony and the other evidence indicates that she has suffered the same symptoms, without interruption, since the injury. We find that, whatever the objective medical diagnosis of the wrist condition, the symptoms of which claimant complained at the time when she was examined by Stolzberg were the same symptoms that she had suffered since her work injury in September, 1980, and that she continued to suffer at the time of the hearing.

The medical evidence as to the cause of the current symptoms is divided. Neither Robertson nor Reilly expressed

his opinion in detail, and neither opinion reflects much analysis. For several reasons, however, we find Robertson's opinion to be more persuasive. Reilly never examined claimant; he formed his opinion only from the medical records. His conclusory statement that claimant's wrist condition is not related to the injury, because it is related to her pregnancy, is not persuasive.

Robertson, on the other hand, has treated claimant since 1980 and has first-hand knowledge of her entire medical history relating to her wrist. He examined her before, during and after her pregnancy, and noted the same symptoms throughout. He is in a superior position to evaluate her condition. *See Weiland v. SAIF,* 64 Or App 810, 669 P2d 1163 (1983). Although he did note in his charts that the current symptoms should disappear after pregnancy, that is not inconsistent with his later opinion that the symptoms claimant continues to suffer after her pregnancy are related to the 1980 injury. His opinion, together with claimant's testimony concerning her continued symptoms, lead us to conclude that her present wrist condition is related to the 1980 injury, and that treatment of it is compensable. *See Bradshaw v. SAIF,* 69 Or App 587, 687 P2d 165 (1984).

Reversed and remanded.

IN THE COURT OF APPEALS OF THE STATE OF OREGON

In the Matter of the Compensation of Rosalie A. Sheldon, Claimant.

WEYERHAEUSER COMPANY,
Petitioner,

v.

SHELDON,
Respondent.

(WCB 85-14077; CA A40975)

Judicial Review from Workers' Compensation Board.

Argued and submitted April 3, 1987.

J. W. McCracken, Jr., Eugene, argued the cause and filed the brief for petitioner.

James L. Edmunson, Eugene, argued the cause for respondent. With him on the brief was Malagon & Moore, Eugene.

Before Buttler, Presiding Judge, and Warren and Rossman, Judges.

BUTTLER, P. J.

Affirmed.

BUTTLER, P. J.

Employer seeks review of an order of the Workers' Compensation Board requiring it to pay claimant's attorney fees for services in obtaining increased compensation. We affirm.

Claimant sustained a compensable injury in 1979. Employer overpaid claimant compensation for temporary total disability in the amount of $9,476.21. By a determination order, claimant was awarded permanent partial disability, with a lump sum value of $5,440. The order also provided that employer was not entitled to an offset against the award for the prior overpayment. Employer paid that award. Claimant requested a hearing, contending that she was entitled to a greater award for her permanent partial disability. Employer contended that it was entitled to offset the overpayment against any increase in claimant's award. The referee increased claimant's award for permanent partial disability by $4,080 and awarded claimant's attorney a fee equal to 25 percent of the increased award, or $1,020, payable out of the increased compensation. He allowed employer to offset the previous overpayment against the increased award of compensation. Because the overpayment was greater than the amount of the increased award, claimant did not actually receive any additional payment.

Claimant then sought payment of her attorney fees from employer and, when employer refused, she requested another hearing. The referee ordered employer to pay the fee, together with a penalty and attorney fee for the additional proceeding. The Board affirmed and adopted the order of the referee.

The referee concluded that employer's obligation to pay claimant an amount equal to the awarded attorney fee stems from OAR 438-47-085(2):

> "An attorney fee which has been approved in accordance with 47-025 or 47-030 to be paid from increased compensation awarded by a referee, the Board or the Court of Appeals shall not be subject to any set-off based on prior overpayment of compensation to claimant by the employer or its insurance carrier. The employer or carrier shall pay the approved attorney fee to the claimant's attorney."[1]

Because the full amount of claimant's additional award of compensation was not as great as the overpayment, the rule requires employer to pay the amount necessary to cover claimant's approved attorney fees, because there is no offset as to that amount. Employer contends that, if the rule is applied here, it would result in an employer-paid attorney fee, even though none is authorized by statute in this case. It does

[1] OAR 438-47-025 provides:

"In a proceeding before a referee requested by claimant on the extent of permanent disability, a fee of 25 percent of any increase in permanent disability awarded by the referee, but not more than $2,000, shall be approved for claimant's attorney."

not, however, challenge the validity of the rule. As we read the rule, however, it provides that, even though there has been an overpayment for which an employer may otherwise be entitled to an offset in some amount from the increased award of compensation, the allowable offset is reduced by the amount necessary to cover an approved attorney fee payable out of the increased award.

"Necessary adjustments in compensation" are authorized by ORS 656.268, subsection (4)[2] of which applies to the Evaluation Division and subsection (6)[3] of which applies

to the Board on review. Thus, the Board has authority to authorize offsets, *Forney v. Western States Plywood,* 66 Or App 155, 672 P2d 1376 (1983), *aff'd* 297 Or 628, 686 P2d 1027 (1984), and also has authority to adopt rules "reasonably required in the performance of its duties." ORS 656.726(4). Attorney fees payable out of the award are part of a claimant's compensation, *SAIF v. Gatti,* 72 Or App 106, 694 P2d 1020 (1984), *rev den* 299 Or 314 (1985),[4] and the effect of OAR 438-47-085(2), adopted by the Board, is to make a "necessary adjustment in compensation" by limiting the offset in cases such as this.[5]

Because the result of the Board's decision under its rule is to reduce the amount of the offset by $1,020, that amount of compensation remains owing to claimant out of the additional award of compensation, and that amount is payable to claimant's attorney under the rule. The Board did not err.[6]

Affirmed.

---

[2] ORS 656.268(4) provides:

"Within 10 working days after the Evaluation Division receives the medical and vocational reports relating to a disabling injury, the claim shall be examined and further compensation, including permanent disability award, if any, determined under the director's supervision. If necessary the Evaluation Division may require additional medical or other information with respect to the claim, and may postpone the determination for not more than 60 additional days. Any determination under this subsection may include necessary adjustments in compensation paid or payable prior to the determination, including disallowance of permanent disability payments prematurely made, crediting temporary disability payments against permanent disability awards and payment of temporary disability payments which were payable but not paid. The Evaluation Division shall reconsider determinations made pursuant to this subsection whenever one of the parties makes request therefore and presents medical information regarding the claim that was not available at the time the original determination was made. However, any such request for reconsideration must be made prior to the time a request for hearing is made pursuant to ORS 656.283. The time from request for reconsideration until decision on reconsideration shall not be counted in any limitation on the time allowed for requesting a hearing pursuant to ORS 656.283."

[3] ORS 656.268(6) provides:

"The Evaluation Division shall mail a copy of the determination to all interested parties. Any such party may request a hearing under ORS 656.238 on the determination made under subsection (4) of this section within one year after copies of the determination are mailed."

[4] On the other hand, attorney fees payable by the insurer or self-insured employer are not part of a claimant's compensation. *Dotson v. Bohemia, Inc.,* 80 Or App 233, 236, 720 P2d 1345, *rev den* 302 Or 35 (1986).

[5] The rule may address a concern on the part of the Board that claimants who have received overpayments might otherwise have difficulty obtaining legal representation in attempts to secure an increased award.

[6] Although employer also assigns error to the Board's award of a penalty and attorney fees in this proceeding, it does not argue that point. We assume that its argument is contingent on our reversing the Board on the question argued and decided.

IN THE COURT OF APPEALS OF THE
STATE OF OREGON

In the Matter of the Compensation of
Leokadia W. Piwowar, Claimant.
GEORGIA-PACIFIC CORPORATION,
Petitioner,
v.
PIWOWAR,
Respondent.
(WCB 82-09391 and 83-07720; CA A38112)
(Cases Consolidated)

Judicial Review from Workers' Compensation Board.

Argued and submitted February 11, 1987.

George Goodman, McMinnville, argued the cause for petitioner. With him on the brief was Cummins, Cummins, Brown & Goodman, P.C., McMinnville.

Linda Love, Portland, argued the cause for respondent. On the brief were James L. Francesconi and Francesconi & Cash, P.C., Portland.

Before Buttler, Presiding Judge, and Warren and Rossman, Judges.

WARREN, J.

Portion of Board order no. 82-09391 overturning employer's denial of ankylosing spondylitis reversed; that order otherwise affirmed; Board order no. 83-07720 affirmed.

WARREN, J.

This workers' compensation case concerns whether, after the issuance of a determination order, an employer may partially deny a claim and refuse to pay compensation awarded by the determination order.

Claimant experienced a minor back injury in August, 1981, which employer admits that it accepted. During the year following the injury, claimant's symptoms were diagnosed alternatively as lumbosacral strain and ankylosing spondylitis. By late 1982, the medical evidence indicated that claimant was medically stationary, and in December, 1982, employer requested claim closure. A determination order awarded 40 percent permanent partial disability. Claimant filed a request for hearing, but employer did not. Then, in February, 1983, on the basis of a medical report which indicated that the only cause of claimant's permanent disability was the noncompensable ankylosing spondylitis, employer issued a partial denial of the claim. It also stopped paying permanent partial disability benefits.

The referee treated the partial denial as a request for hearing and consolidated the hearing on the partial denial with the hearing on the determination order. He upheld the partial denial and found that claimant was not entitled to an

award of permanent partial disability. However, the referee ordered employer to pay the permanent partial disability benefits which were due and unpaid on the date of his order. He assessed a penalty and attorney fees based on that amount. Both employer and claimant appealed. The Board's order on reconsideration affirmed the referee's order, except that it held that employer was precluded by *Bauman v. SAIF*, 295 Or 788, 670 P2d 1027 (1983), from denying the ankylosing spondylitis.

Pending Board review, employer refused to pay the benefits, penalty and attorney fees ordered by the referee, and claimant requested a hearing to enforce the referee's order. The second referee ordered employer to pay the amount ordered by the first referee pending Board review of that order. He assessed no penalty. The Board affirmed the second referee but assessed a penalty for employer's failure to pay the amount ordered by the first referee.

Employer seeks review of both Board orders. Because claimant does not challenge either order, we do not review the Board's determination that claimant's disability is not compensable or decide whether that question was properly before the referee and the Board.

The first question is whether employer could deny the compensability of the ankylosing spondylitis. We conclude that it could, in view of the Supreme Court's recent opinion in *Johnson v. Spectra Physics*, 303 Or 49, 733 P2d 1367 (1987). The claim form which claimant had filed described the injury as "sore back." There is no indication on that form that employer accepted the claim, but it acknowledges that it did. 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*. Employer never expressly accepted the ankylosing spondylitis; it could deny it at any time, although a late denial would subject it to a penalty. ORS 656.262(10). The Board erred in holding that the denial was precluded by *Bauman*.

The next issue is whether the Board properly upheld the referee's order requiring employer to pay a penalty and attorney fees, as well as permanent partial disability benefits which were due under the determination order but unpaid at the time of the referee's order. Employer contends, relying on ORS 656.262(2), that its duty to pay benefits ended when it denied the claim. That subsection provides that an employer's duty to pay compensation commences promptly on notice of the claim "except where the right to compensation is denied * * *." As we understand the quoted portion, it deals only with when the duty to pay benefits *does not begin*, not with when it ends; it does not permit an employer unilaterally to terminate benefits awarded by a determination order on an accepted claim. To permit an employer to avoid the payment of benefits which have been awarded simply by denying the claim, or a portion of it, and stopping payment would defeat the objective of prompt claim processing. Employer's remedy was to challenge the determination order through the ordinary hearing process. Only if it obtained a favorable ruling, could it termi-

nate benefits. Its unilateral termination of benefits was unreasonable, and we conclude that that termination justified the

assessment of a penalty and attorney fees under ORS 656.262(10). *See Hutchison v. Louisiana Pacific,* 67 Or App 577, 679 P2d 338, *rev den* 297 Or 340 (1984). Additionally, the Board correctly held that employer must pay claimant the benefits which were due and unpaid on the date of the referee's order reversing the award. *See Hutchison v. Louisiana Pacific, supra,* 67 Or App at 581; *see also Hoke v. Libby, McNeil & Libby,* 81 Or App 347, 724 P2d 940 (1986).

The Board assessed an additional penalty against employer, because it held that the payment ordered by the referee (other than the separate penalty and attorney fee) was "compensation" under ORS 656.313, which should have been paid pending appeal to the Board. Employer asserts that the payment ordered was not "compensation," because it was not payable for disability, as required by ORS 656.313(4), because the referee had determined that claimant had no permanent compensable disability. Although it was later determined by the referee and the Board in the other appeal that claimant had no compensable permanent partial disability, when the award was made it was for disability. As we have already held, claimant was entitled to that award until the determination order was overturned by the referee. The referee properly ordered the payment of the delinquent benefits. Employer's failure to pay them was unreasonable, and we uphold the penalty. *Georgia-Pacific v. Hughes,* 85 Or App 362, 736 P2d 602 (1987).

That portion of Board order no. 82-09391 overturning employer's denial of ankylosing spondylitis is reversed; the order is otherwise affirmed; Board order no. 83-07720 is affirmed.

IN THE COURT OF APPEALS OF THE
STATE OF OREGON

In the Matter of the Compensation of
Jerry W. Wine, Claimant.
NORTHWEST FARM BUREAU
INSURANCE COMPANY et al,
Petitioners,
v.
WINE et al,
Respondents.

(WCB 82-10473, 84-04838, 85-03699; CA A39828)

Judicial Review from Workers' Compensation Board.

Argued and submitted March 20, 1987.

Paul J. De Muniz, Salem, argued the cause for petitioners. With him on the brief was Garrett, Seideman, Hemann, Robertson & De Muniz, P.C., Salem.

Christine Chute, Assistant Attorney General, Salem, argued the cause for respondents SAIF Corporation and Hoskinson Logging. With her on the brief were Dave Frohnmayer, Attorney General, and Virginia L. Linder, Solicitor General, Salem.

L. Thomas Clark, Bend, filed the brief for respondent Jerry W. Wine.

Before Warden, Presiding Judge, and Joseph, Chief Judge,* and Van Hoomissen, Judge.

VAN HOOMISSEN, J.

Affirmed.

---

* Joseph, C. J., *vice* Young, J.

VAN HOOMISSEN, J.

Northwest Farm Bureau (Northwest) seeks review of a Workers' Compensation Board order holding that Northwest is responsible for claimant's aggravation claim. It contends that the Board misapplied the "last injurious exposure" rule and that SAIF is the responsible insurer. On *de novo* review, ORS 656.298, we affirm.

In September, 1975, claimant broke his right leg while working as a timber faller for SAIF's insured. SAIF accepted his claim. His injury required several surgeries. As a result, his right leg is one and one-quarter inches shorter than his left leg. That condition has also caused him back pain. He was awarded 85 percent permanent disability for the loss of the use of his right leg.

In June, 1981, claimant began working for Northwest's insured as a mechanic. In July, 1982, while sliding a wooden motor carrier out of his way, he felt a sharp pain in his back. His family physician, Dr. Detweiler, diagnosed low back strain. He also saw evidence of degenerative arthritis of the spine. He referred claimant to Dr. Carroll. Claimant filed an aggravation claim against SAIF and a new injury claim against Northwest. SAIF denied the aggravation claim; Northwest accepted the new injury claim. Claimant was treated for low back strain. He returned to light duty work after about three weeks. He agrees that his back pain returned to its pre-July, 1982, level by August, 1982, when his claim was closed.

In August, 1983, claimant went to Carroll, complaining of increased back pain. He saw him again in March, 1984. Claimant filed an aggravation claim with Northwest, which was denied. Northwest concluded that his compensable back condition of July, 1982, had not worsened and that his back problems resulted from his 1975 injury.

In April, 1984, Carroll wrote, in relevant part:

> "I cannot deny, at the time I saw the patient for Dr. Detwiler in September of 1982, that I felt that the July 1982 episode was an acute injury and significantly independent from his other back complaints. However, the patient's back problems at the present time are not due to this one episode of back strain. They are due to overall leg discrepancy and the

fact that the patient has carried around a cast and been immobilized for a period of almost five years from the initial injury in September of 1975 to his last office visit here for still questionable healing of the fracture in the right leg in November of 1980, at which time he was even still wearing a brace. This shortening of the right leg and walking in casts for many years has caused a deformity and arthritis of the lower spine, which is now symptomatic. The patient has been wearing a lift, but frequently is without it, especially in the evening. I feel so strongly about the continued back pain that I think the patient is a candidate at this time for consideration of shortening of the good left leg through an improved intermedullary technique in the left femur. This would be recommended in order to try to head off any further back problems."

Orthopaedic Consultants examined claimant in May. It reported:

"It is the opinion of the examiners that it appears that patient's back complaints began principally following the leg injury and were aggravated substantially by the lifting events of 1982."

In June, Carroll concurred with Orthopaedic Consultants. In September, Carroll stated, in relevant part:

"After reviewing this case once more, I would like to reiterate that I believe that [claimant's] back problem is an ongoing condition which became symptomatic and continues to be symptomatic, solely due to his 1975 injury and has not been materially contributed by the July 1982 incident. In reviewing the Orthopaedic Consultants' analysis of the problem, I agree with their examination and findings, but in all fairness, I think their conclusion that the leg injury was aggravated substantially by the lifting event of 1982 is not accurate. I would place the greatest blame for the patient's ongoing symptoms on his original injury."

During his deposition, Carroll was asked about that statement. He explained:

"That was a harsh statement. I, perhaps, should not have agreed to sign that. You were kind enough to later on in the paragraph, to modify your stance a little bit, so I accepted it.

" 'In reviewing Orthopaedic Consultants' analysis * * * I agree from their examination and findings, but in all fairness, I think that their conclusion that the leg injury was aggravated substantially by the lifting in 1982 was not accurate. I would place the greatest to [sic] blame on [sic] the patient's

ongoing symptoms on his original injury,' meaning that there is consideration, I would say by that statement, that there is consideration of the other injury. But, the 1982 injury, I felt was minor compared to the total overall picture."

In April, 1985, Carroll reported:

"I think that [claimant's] back condition is primarily a result of his old injuries in 1975 and 1982, and can be considered the expected progression of the underlying condition from these accidents."

Claimant testified that he had had some back problems since his 1975 leg injury but that the 1982 incident resulted in immediate pain and a need to seek medical treatment. He stated that his back condition has continued to

worsen without any further injuries or incidents and that he suffers "quite a bit" more pain than he did before the 1982 incident. The referee found claimant to be a credible and reliable witness. He concluded:

> "Based upon the current state of the law that the second employer remains responsible if the injury which occurred while in its employ contributed independently to the claimant's condition, I find Northwest Farm Bureau to be the responsible party in this matter. Dr. Carroll, in his deposition, stated the 1982 injury contributed, albeit in a minor way, to the progression of the underlying condition. The 1975 injury covered by SAIF may have been the major cause, but that is not the criteria [sic] used to determine responsibility."

The Board affirmed, and Northwest appeals.

In *Industrial Indemnity Co. v. Kearns*, 70 Or App 583, 690 P2d 1068 (1984), we approved the Board's rule that states, in part:

> " 'Where there are multiple accepted injuries involving the same body part, we will assume that the last injury contributed independently to the condition now requiring further medical services or resulting in an additional disability, and the employer/insurer on the risk at the time of the most recent injury has the burden of proving that some other accepted injury last contributed independently to the condition which presently gives rise to the claim for compensation; e.g., that its accepted injury caused only symptoms of the condition or involved a different condition affecting the same body part.' " 70 Or App at 585.

See Boise Cascade Corp. v. Starbuck, 296 Or 238, 244, 675 P2d 1044 (1984). Under *Kearns*, when the successive accepted claims are for injury to the same body part, there is a rebuttable presumption that the last injury contributed independently to the worsened condition and that the insurer at that time is responsible. Therefore, the burden was on Northwest, the second insurer, to prove that the 1982 injury did not contribute independently to claimant's back condition.

Claimant's testimony and the medical evidence demonstrate that he had had some back problems before the July, 1982 incident, but that his condition was worse after the incident. Although he recovered temporarily from the incident, we agree with the referee and the Board that Northwest has not met its burden. Therefore, Northwest is responsible.

Affirmed.

IN THE COURT OF APPEALS OF THE
STATE OF OREGON

In the Matter of the Compensation of
Clifford J. DuVal, Claimant.

U. S. BAKERY,
Petitioner,

v.

DUVAL,
Respondent.

(WCB 84-12417; CA A40810)

Judicial Review from Workers' Compensation Board.

Argued and submitted March 20, 1987.

Kenneth L. Kleinsmith, Portland, argued the cause and filed the brief for petitioner.

Robert J. Thorbeck, Salem, argued the cause for respondent. On the brief was Eileen Fussner, Salem.

Before Warden, Presiding Judge, and Joseph, Chief Judge,* and Van Hoomissen, Judge.

VAN HOOMISSEN, J.

Reversed.

* Joseph, C. J., *vice* Young, J.

VAN HOOMISSEN, J.

Employer seeks review of a Workers' Compensation Board order awarding compensation for claimant's aggravation claim. The issues are compensability and whether employer's denial of claimant's aggravation claim is precluded by *Bauman v. SAIF,* 295 Or 788, 670 P2d 1027 (1983). On *de novo* review, ORS 656.298, we reverse.

In November, 1981, claimant stepped off a loading dock at work and injured his back. Dr. Kelber diagnosed "lumbar strain possible recurrent disc disease." Claimant filed an 801 form, which included boxes numbered 15, 16 and 17, labeled respectively: "nature of injury or disease," "part of body affected" and "describe accident." He wrote on the form "twisted back," "back right" and "carrying cubes off dock in warehouse—stepped off dock and hurt back." Employer accepted the claim by checking the appropriate options included in box 35 of the form. Employer checked "accepted," "disabling" and "injury."[1]

Dr. Melgard examined claimant. He had treated him before, performing a laminectomy in November, 1969, to remove a herniated disc. At that time, he also had diagnosed probable Paget's Disease.[2] Kelber, Melgard and his treating

[1] In box 35, where employer had the option of checking "accepted," "denied" or "deferred," employer also checked "deferred." However, employer does not now argue that the claim was deferred.

[2] Paget's Disease is a progressive disease of unknown etiology. It affects bones, causing them to grow oversized, and weakens the structure of the bones as they grow.

physician, Dr. Tiley, continued to treat him. He was released for work twice in 1982, but his back problem persisted. In July, 1982, he left work permanently. A November, 1982, determination order awarded him 22 percent permanent partial unscheduled disability for his back. A June, 1983, stipulated order increased his award of unscheduled disability.

In August, 1984, claimant suffered back pain while lifting groceries from his car. He filed an aggravation claim, contending that his compensable condition had worsened. Employer denied the aggravation claim on the ground that the condition had not worsened. The October 24 denial letter provided, in relevant part: "We accepted your claim for your lumbrosacral strain, and related pagets [sic] disease and have

continued to provide benefits to you for this condition." In June, 1985, employer "clarified" its denial, telling claimant that its denial letter, which stated that it had accepted Paget's Disease was a "misstatement of your employers [sic] position."

The referee concluded, in relevant part:

> "The partial denial dated October 24, 1984, specifically denies the aggravation claim, but accepts the claim for lumbrosacral strain and the related Paget's disease. Once a claim has been accepted the insurer may not subsequently deny the compensability of the underlying claim, *Bauman v. SAIF,* 295 Or 788 (1983). Paget's disease has become a part of this claim prior to the Determination Order and stipulated settlement. Consequently, it cannot now be denied."

The referee vacated the denial and remanded the claim for payment of compensation from July 6, 1984. Thereafter, the referee allowed employer's motion to reopen for reconsideration. On reconsideration, the referee affirmed his previous order, except that he held that compensation would be due from August 13, 1984. He also stated that, if *Bauman* did not bar denial, the claim would not be compensable. The Board adopted the referee's modified order and affirmed.

Employer contends that the Board erred in ruling that it was barred from denying the compensability of claimant's Paget's Disease. Employer argues that its acceptance of the original claim was an acceptance of back strain only. It also argues that the only condition which it specifically and officially accepted by checking the boxes on the 801 form was the back strain described by the claimant on the form. *See Johnson v. Spectra Physics,* 303 Or 49, 733 P2d 1367 (1987). It argues that, because Paget's Disease was never accepted, *Bauman v. SAIF, supra,* does not apply. Claimant argues that employer knew from the medical records that Paget's Disease was part of his original claim.

If, after the last award or arrangement of compensation, conditions resulting from the original injury worsen, an injured worker is entitled to additional compensation. ORS 656.273. On *de novo* review, we find that the preponderance of the evidence in the record indicates that claimant's worsened condition is due to the natural progression of Paget's Disease,

independent of the injury; there has been no worsening resulting from the original injury itself.[3] Hence, the compensability of claimant's aggravation claim depends entirely on whether Paget's Disease was a compensable aspect of his original claim.

The disease was not caused by the injury. The evidence indicates that the effect of the disease in the original injury was to increase the extent of disability caused by the original injury. The back strain, which would otherwise have been a minor injury, caused a compression fracture of the disease-weakened vertebra at L3. Thus, the disease affected the extent of claimant's disability but did not itself become a compensable aspect of the claim. *See Barrett v. D & H Drywall,* 300 Or 325, 709 P2d 1083 (1985), *on reconsideration,* 300 Or 553, 555, 715 P2d 90 (1986).

Because Paget's Disease itself was not compensable, it is not a compensable aspect of the original claim, unless employer *accepted* it. In *Bauman* the Supreme Court held:

> "[O]nce an insurer has accepted a claim under ORS 656.262(6), which requires acceptance or denial of a Workers' Compensation claim within 60 days after the employer has notice or knowledge of the claim, the insurer may not subsequently deny the compensability of the underlying claim." 295 Or at 790.

After the Board's order here, the Supreme Court clarified the question of when a claim has been accepted for the purposes *Bauman.* In *Johnson v. Spectra Physics, supra,* the court explained:

> "*Bauman* applies only to a claim 'specifically' or 'officially' accepted by the insurer. 295 Or at 793-94. * * * An insurer must accept a particular claim in writing, and subsequently deny that particular claim after the 60 days prescribed by ORS 656.262(6) have elapsed, before *Bauman* applies." 303 Or at 55.

In *Johnson,* the claimant had filed an 801 form stating that she had injured her back and right arm. Before the

insurer accepted her claim, it received a medical report indicating that she was suffering a bilateral carpal tunnel syndrome, which her doctor believed was work related. Eight days later, the insurer accepted Johnson's claim by checking the "accepted" box on the same form that she had submitted. Eighty days after the insurer received the report of carpal tunnel syndrome, it notified claimant that it was denying the compensability of the syndrome, although it still accepted the back injury. The Supreme Court characterized the carpal tunnel syndrome and the back injury as separate "aspects" of one claim.[4] Although notice of both the back injury and the syndrome came to the insurer through the same claim process,

[3] We do not detail the facts. *See Bowman v. Oregon Transfer Company,* 33 Or App 241, 576 P2d 27 (1978).

[4] The Supreme Court noted that the carpal tunnel syndrome claim arose during the processing of the back claim and that the insurer assigned one claim number to both conditions.

each aspect could be treated as a separate claim, allowing for partial acceptance or denial by the insurer. *See Johnson v. Spectra Physics, supra,* 303 Or at 58.[5]

The court noted that, although the medical report indicated that Johnson's carpal tunnel syndrome arose from her work, it did not indicate that the syndrome arose from the injury, which was the subject of her 801 form. Rather, the report constituted notice of a second compensable injury, this time an occupational disease, within the same claim process. The court explained:

> "[W]hen a claimant makes a single claim encompassing two *separate* injuries or conditions, the insurer then may partially deny that claim by specifically denying one injury or condition while accepting the other." 303 Or at 58. (Emphasis supplied.)

The court reasoned that the insurer, by checking the "accepted" box, had accepted only the back strain mentioned on the form. The court stated that the insurer's silence about the carpal tunnel syndrome was not a denial or an acceptance and that, because the insurer had not officially or specifically accepted the bilateral carpal tunnel syndrome, *Bauman* did not bar denial of the syndrome. 303 Or at 58. Thus, the insurer could deny the syndrome, although it might be subject to

penalties because it had failed to respond within 60 days of its receipt of the medical report notifying it that the syndrome arose from claimant's work. ORS 656.262(10); *Johnson v. Spectra Physics, supra,* 303 Or at 58-59.

In the present case, employer officially accepted claimant's stated claim. The only injury or disease specified was a twisted back, which employer accepted. That was an acceptance of all conditions which were caused by the back injury. It was not an acceptance of Paget's Disease, which was neither specified on the form nor caused by the injury.[6]

In *Johnson,* the medical report of work-related carpal tunnel syndrome constituted notice to insurer of a new, facially compensable, aspect of the claim. Here, employer received a later medical report indicating that claimant suffered Paget's Disease, among other conditions. However, the report did not indicate that the disease arose from, or was worsened by, the accepted injury[7] or arose out of any other work context. Without an allegation that the disease arose from work, the medical report did not constitute a claim. ORS 656.005(7); ORS 656.005(8)(a). The absence of notice to employer that claimant was asserting that the disease arose from his employment prevents the medical reports of Paget's Disease from constituting a claim.

---

[5] A medical report concerning an occupational disease which may arise out of employment is notice of an injury sufficient to constitute a claim. ORS 656.265; ORS 656.802; ORS 656.804.

[6] In *Johnson,* the insurer accepted the back injury by checking the "accepted" box on the form. That met the requirement of specifically or officially accepting or denying the claim *in writing.*

[7] If the medical report had indicated that the already accepted injury had caused Paget's Disease, employer, at the hearing, could have contested that as a factual issue of causation.

Alternatively, claimant argues that the language of employer's letter denying the compensability of his aggravation claim estops it from denying the compensability of Paget's Disease. The referee concluded that the letter accepted the disease. We disagree. The letter states:

> "We accepted your claim for your lumbrosacral strain, and related pagets [*sic*] disease and have continued to provide benefits to you for this condition."

We construe the mention of Paget's Disease to be a recognition of the role that the disease played in the extent of disability caused by the compensable injury. Furthermore, the

term "accepted" precludes the interpretation of the letter itself as an acceptance of the disease at the time it was sent.

In sum, Paget's Disease was not a compensable aspect of claimant's original claim. It was not accepted by employer in response to claimant's aggravation claim, and it is not causally related to his injury. Because claimant's aggravation is due to a worsening of his Paget's Disease, and not to any worsening of his original injury, it is not compensable.

Reversed.

IN THE COURT OF APPEALS OF THE STATE OF OREGON

In the Matter of the Compensation of Leonard V. Jenkins, Claimant.

JENKINS,
Petitioner,

v.

TANDY CORPORATION et al,
Respondents.

(WCB 85-07550; CA A40502)

Judicial Review from Workers' Compensation Board.

Argued and Submitted April 10, 1987.

Benton Flaxel, North Bend, argued the cause and submitted the brief for petitioner.

Jerald P. Keene, Portland, argued the cause for respondents. With him on the brief was Roberts, Reinisch & Klor, P.C., Portland.

Before Warden, Presiding Judge, and Joseph, Chief Judge,* and Van Hoomissen, Judge.

VAN HOOMISSEN, J.

Reversed and remanded with instructions to accept claim.

* Joseph, C. J. *vice* Young, J.

VAN HOOMISSEN, J.

Claimant seeks review of a Workers' Compensation Board order that affirmed employer's denial of his injury claim. The issue is whether claimant's injury is work-related. ORS 656.005(8)(a); *see Rogers v. SAIF,* 289 Or 633, 616 P2d 485 (1980). On *de novo* review, ORS 656.298, we reverse.

Claimant worked as a salesman and manager of the computer department of employer's store located in the North Bend Shopping Center.[1] The stores in the shopping center are arranged in an "L" shape and front on a large parking lot owned and maintained by the shopping center operator. The parking lot fronts on a public highway. Customers and employes of the shopping center's tenants use the parking lot. Claimant and his co-workers customarily parked in a certain part of the parking lot, approximately 100 feet from employer's premises. They were not required to park there or in the lot at all. Employer did not designate any particular place for its employes to park, but it did specify that they *not* park in the spaces closest to its store so that those spaces would be available for its customers. The nearest alternative public parking area outside the shopping center was about three blocks away.

Employer required claimant to have his personal car available at work to make calls to the homes and businesses of its customers three or four times a week and to make deliveries to the bank or mail box two or three times a week after work. Claimant was paid a commission on sales and usually worked a 56-hour week, for which he was paid an hourly rate. He did not receive reimbursement from employer for driving to and from work. He was reimbursed for use of his car, however, when he billed employer for the service calls that he made which were a part of his job. He would sign in on a time card when he arrived at work and sign out when he left work at the end of the day.

On November 10, 1985, claimant left work about an hour after closing time intending to go to his car and drive directly home. He had worked late doing some job-related

paper work and he had signed out on his time card.[2] After locking the front door of employer's store, he proceeded directly toward his car, which was parked in its customary location. He had taken just a few steps from the employer's front door, when he was struck by a car driven by a customer of one of the shopping center's other tenants and was injured.[3]

The referee upheld employer's denial, explaining, in relevant part:

[1] The lease between employer and the shopping center is not in evidence.

[2] Claimant does not argue that, and we do not decide whether, because he worked overtime on the day he was injured, he came within the "special errand rule" while making his regular trip home. *See* 1 Larson, *Workmen's Compensation Law,* § 16.14 (1985).

[3] When claimant returned to work, he told his supervisor about his injury. A claim was not filed until the following March, because claimant was unaware that the accident might be covered by workers' compensation. Employer did not issue a formal acceptance or denial of the claim, and the case went to hearing on the basis that there had been a *de facto* denial.

"The question of whether an injury occurring in a shopping center parking lot, over which the employer has no evidence of control, would be compensable has not been answered in Oregon. Many other jurisdictions have found such claims to be compensable. *See Montgomery Ward v. Cutter*, 64 Or App 759, 669 P2d 1181 (1983).

"In the instant matter there is no evidence the claimant was required to park in any specific area of the lot. There is no evidence that the employer had any type of control over the lot or responsibility for its maintenance. The claimant had finished work for the day and was on his way home. He did not intend to run any errands for the employer on his way home.

"The claimant was required to have a car available to him for his use to call on customers, as necessary, for the employer; however, I do not believe this to be a sufficient basis upon which to hold the employer responsible for the injury which occurred after work hours in an area over which the employer had no control."

Claimant argues that his claim is compensable under the unitary work-connection approach to the statutory requirement that, to be compensable, an accidental injury must arise out of and in the course of employment. *See Rogers v. SAIF, supra*, 289 Or at 642-44. Under that test, several factors are to be examined in the light of the facts of the case to see if the injury has a sufficient work relationship. If the injury has sufficient

work relationship, then it arises out of and in the course of employment and the statute is satisfied.[4]

Generally, injuries sustained by employes when going to and coming from their regular places of work are not compensable. *Heide/Parker v. T.C.I. Incorporated*, 264 Or 535, 539, 506 P2d 486 (1973); *Philpott v. State Ind. Acc. Com.*, 234 Or 37, 40, 379 P2d 1010 (1963); *Adamson v. The Dalles Cherry Growers, Inc.*, 54 Or App 52, 56, 633 P2d 1316 (1981). There are exceptions, however, to that general rule. If an employe, as part of his job, is required to bring his own car to work for use during his working day, his trip to and from work is, by that fact alone, embraced within the course of employment. *See Giltner v. Commodore Con. Carriers*, 14 Or App 340, 347, 513 P2d 541 (1973); *Casper v. SAIF*, 13 Or App 464, 471-73, 511 P2d 451 (1973); 1 Larson, *Workmen's Compensation Law, supra* n 1. In *Smith v. Workmen's Comp. App. Bd.*, 69 Cal 2d 814, 73 Cal Rptr 253, 447 P2d 365 (1968), Justice Tobriner explained that the modern trend of the cases sanctions recovery in such situations.

"Surely in this day of a highly motorized society we cannot cast the going and coming rule as a protective cloak over the shoulders of the employer who, for his own advantage, demands that the employee furnish the car on the job. Smith's obligation reached out beyond the employer's premises, and, in driving his car to and from them, he did no more than fulfill the condition and requirement of his employment." 69 Cal 2d at 825.

[4] The "arising out of and in the course of employment" requirement for compensability, ORS 656.005(8)(a), has been liberally applied "so as to best effectuate the socio-economic purpose of the Worker's Compensation Act: the financial protection of the worker and his/her family from poverty due to injury incurred in production, regardless of fault, as an inherent cost of the product to the consumer." *Rogers v. SAIF, supra*, 289 Or at 643.

In this case, employer required claimant to bring his personal car to work and to have it available for use in employer's business during the work-day and to make deliveries after work. Claimant was enroute to his car after finishing his work in the store for the day. He had only walked a few feet from the front of the store when he was injured. We conclude that the injury arose out of and in the course of his employment. *See Giltner v. Commodore Con. Carriers, supra;*

Casper v. SAIF, supra; 1 Larson, *Workmen's Compensation Law, supra.* Therefore, it is compensable.[5]

Reversed and remanded with instructions to accept claim.

[5] Claimant also argues that the shopping center parking lot is an extension of employer's premises. *See Kowcun v. Bybee,* 182 Or 271, 186 P2d 790 (1947); *Montgomery Ward v. Cutter, supra; Rohrs v. SAIF,* 27 Or App 505, 556 P2d 714 (1976). Employer denies that the parking lot is an extension of its premises. It argues that it had no control of the lighting, traffic or other conditions in the parking lot. It also argues that claimant was no longer in the course of his employment when he was injured because he had signed out for the day and was not going to run any errands for employer on his way home that evening. Because we conclude for other reasons that claimant's injury arose out of and in the course of his employment, we need not address his alternative theory of compensability.

IN THE COURT OF APPEALS OF THE STATE OF OREGON

In the Matter of the Compensation of William H. Kahl, Claimant.

KAHL,
Petitioner,

v.

SAIF CORPORATION et al,
Respondents.

(82-10923, 82-00907; CA A39161)

Judicial Review from Workers' Compensation Board.

Argued and submitted December 5, 1986.

Roger Ousey, Eugene, argued the cause for petitioner. On the brief were Jerome F. Bischoff, and Bischoff & Strooband, P.C., Eugene.

Christine Chute, Assistant Attorney General, Salem, argued the cause for respondents. With her on the brief were Dave Frohnmayer, Attorney General, Virginia L. Linder, Solicitor General, and Jeff Ellis, Certified Law Student, Salem.

Before Richardson, Presiding Judge, and Newman and Deits, Judges.

DEITS, J.

Reversed and remanded.

DEITS, J.

On December 12, 1983, a referee issued an order denying claimant's aggravation claim. Claimant mailed a request for review to the Workers' Compensation Board less than 30 days after the order was issued. The letter to the Board was properly addressed, except that apparently the address included the zip code 97312, which is used exclusively by SAIF, instead of the correct zip code, 97310.[1] The Board has no record of receipt of the request, but the Board's original copy of the request for review addressed to the Board was found in SAIF's files.

In September, 1984, claimant's counsel contacted the Board to request a transcript and to ask the Board to proceed with the case. He received no response and again contacted the Board in March, 1985. In November, 1985, claimant's attorney received a transcript. The Board's cover letter stated that review had been requested on December 19, 1983. On December 23, 1985, SAIF moved to dismiss the request for review on the ground that the request was not timely filed with the Board. The Board concluded that claimant's request for review was misaddressed and, therefore, was not mailed to or received by the Board within the required 30 days. The Board held that it was without jurisdiction and dismissed the request for review. We reverse.

Claimant argues that the Board erred in concluding that he had failed to prove by a "preponderance of the evidence" that the request was mailed within the statutory time limits. ORS 656.289(3) provides that 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 a review by the Board under ORS 656.295." ORS 656.295(2) requires that the request be mailed to the Board and that copies be mailed to all parties.

At all pertinent times, there were no specific provisions in the statute or administrative rules establishing how the mailing required by ORS 656.295 must be proven.[2] The

evidence is persuasive that claimant put the letter in the mail addressed to the proper party at the correct street address. The only error which might have been made was in the zip code. The delivery by the Postal Service to a zip code instead of a street address does not nullify the fact that claimant complied with the requirement that he mail a request for review to the Board within 30 days of the referee's order. Service was adequate.

Reversed and remanded.

[1] The Board took judicial notice that SAIF's zip code belongs to no other postal patron.

[2] An administrative rule now provides that the minimum acceptable proof of mailing is a "receipt stamped by the post office showing the date mailed and the certified or registered number." OAR 438-05-040(4)(b).

IN THE COURT OF APPEALS OF THE
STATE OF OREGON

WILSON,
dba Wilson Chiropractic Clinic, P. C.
Petitioner,

v.

WORKERS' COMPENSATION DEPARTMENT,
Respondent.

(2-1986; CA A40561)

Judicial Review from Workers' Compensation Department.

Argued and submitted February 18, 1987.

Brian R. Whitehead, Salem, argued the cause and filed the brief for petitioner.

Richard D. Wasserman, Assistant Attorney General, Salem, argued the cause and filed the brief for respondent. With him on the brief were Dave Frohnmayer, Attorney General, and Virginia L. Linder, Solicitor General, Salem.

Peter W. McSwain, and Francesconi & Cash, P.C., Portland, filed a brief *amicus curiae* for Oregon Chiropractic Physicians Assn.

Before Richardson, Presiding Judge, and Newman and Deits, Judges.

DEITS, J.

Rule held valid.

DEITS, J.

Petitioner challenges the validity of a fee schedule adopted as an administrative rule by the Workers' Compensation Department. The schedule allows licensed physical therapists to be paid a greater maximum fee than other health professionals, such as chiropractors and osteopaths, are paid for the same services. We hold that the rule is valid.

Petitioner contends that the adoption of the fee schedule exceeded the authority granted the director by ORS 656.248(1):[1]

> "The director, in compliance with ORS 183.310 to 183.550 and 656.794, shall promulgate rules for medical fee schedules. These schedules shall represent the 75th percentile of usual and customary fees as determined by the director who shall determine those fees on the basis of generally accepted descriptions of medical service."

[1] Petitioner also challenges the rule as a violation of ORS 656.248(4), which provides:

> "If no usual and customary fee has been established for a given service or procedure the director may, in compliance with ORS 183.310 to 183.550 and 656.794, promulgate a reasonable rate, *which shall be the same within any given area for all primary health care providers* to be paid for that service or procedure." (1985 amendment emphasized.)

The subsection is not applicable, because physical therapists are not primary providers. *Amicus* so concedes. Physical therapists can perform therapy only upon referral. ORS 688.130.

Petitioner argues that his position is supported not only by the language of the statute but by the legislative history as well.

We conclude that adoption of the rule was within the director's authority. First, the plain language of the statute allows the director to establish schedules. Petitioner argues that the requirement in the statute that fees be based on "generally accepted descriptions of medical service" limits the director's authority, because there are no generally accepted descriptions which differentiate between types of medical providers. However, that requirement in the statute has no relevance to the director's authority to adopt fee schedules. "Generally accepted descriptions" refers to physicians' Current Procedural Terminology (CPT),[2] an American Medical

Association established code which uniformly describes procedures or services but without reference to the profession of the provider. The use of the CPT does nothing to limit the number of fee schedules the director may adopt, but rather insures that providers and insurers use the same terminology in their billing process.

Petitioner also argues that the legislative history supports an interpretation of ORS 656.248(1) limiting the director's authority, because language that formerly expressly gave the director the authority to adopt more than one schedule was removed from the statute. Petitioner's reliance on the legislative history is in error. We agree with respondent that the history of ORS 656.248(1) shows a legislative intent that the director be permitted to adopt fee schedules which establish different fees for different professions. The 1971 version of ORS 656.248(1) allowed payment for medical services to be the "usual fee charged by a vendor for similar service." Petitioner concedes that, under that version of the statute, fees could differ on the basis of the profession of the provider. In 1981, as part of the revision of the Workers' Compensation law, the legislature eliminated the reference to vendors' usual fees.[3] However, the elimination of that reference does not prevent the director from differentiating among providers in establishing fees. The legislature permitted the continuation of the distinction by authorizing rules for medical fee schedules. The 1985 amendments did not change the director's authority to promulgate schedules.

Petitioner's last challenge is that the schedules violate Article I, section 20, of the Oregon Constitution and the federal Equal Protection Clause. Under either the state analysis, *see Cooper v. OSAA*, 52 Or App 425, 629 P2d 386, *rev den* 291 Or 504 (1981), or the federal rational relationship test, the contention is without merit.

Rule held valid.

---

[2] CPT is a system by which procedures or services are identified by a five digit code. To each CPT the director has assigned a relative value which is to be multiplied by a conversion factor. The difference in fees comes from the assigned relative values, not from variations in use of the code.

[3] The version of ORS 656.248 adopted in 1981 provided, in part:

"(1) The director, in compliance with ORS 183.310 to 183.550 and 656.794, shall promulgate rules for medical fee schedules and shall update such schedules on a periodic basis. In promulgating such rules the director shall consider:

"(a) Medical service coding;

"(b) Usual and customary medical service fees[.]"

IN THE COURT OF APPEALS OF THE
STATE OF OREGON

In the Matter of the Compensation of
Doris Staack, Claimant.

STAACK,
Petitioner,

v.

SANTIAM MEMORIAL HOSPITAL et al,
Respondents.

(WCB 75-01511; 85-03614; 85-01512; CA A41145)

Judicial Review from Workers' Compensation Board.

Argued and submitted May 4, 1987.

Bruce D. Smith, Salem, argued the cause for petitioner. On the brief was Stanley Fields, Salem.

Jas. Jeffrey Adams, Portland, argued the cause for respondent Santiam Memorial Hospital. With him on the brief was Acker, Underwood & Smith, Portland.

J. Richard Scruggs, Portland, argued the cause for respondents Salem Memorial Hospital and Liberty Northwest Insurance Corporation. With him on the brief was Williams & Zografos, Portland.

Christine Chute, Assistant Attorney General, Salem, argued the cause for respondent State Accident Insurance Fund. With her on the brief were Dave Frohnmayer, Attorney General, and Virginia L. Linder, Solicitor General, Salem.

Before Warden, Presiding Judge, and Van Hoomissen and Rossman, Judges.

WARDEN, P. J.

Reversed as to Santiam Memorial Hospital and remanded with instructions to award benefits for medical services; otherwise affirmed.

WARDEN, P. J.

Claimant seeks review of a Workers' Compensation Board order which she contends erroneously denied her benefits for medical services from her previous employer, erroneously applied the major causation test to deny her occupational disease claim against her later employer and erred by not "shifting" liability from the first employer to the second. We reverse on the medical services issue.

Claimant is a surgical nurse. In 1976, while employed by Santiam Memorial Hospital (Santiam), she filed an occupational disease claim for degenerative osteoarthritis in her right ankle and both knees. After initially denying the claim, Liberty Northwest Insurance Corporation (Liberty),

Santiam's insurer, was ordered by the referee to accept it. Claimant underwent multiple surgeries on her left knee and had partial knee replacement surgery on her right knee. In 1979, her claim was closed with an award of permanent partial disability of 25 percent loss of her right leg and 35 percent loss of her left. The award was later increased to 55 percent of the right leg and 60 percent of the left.

Claimant returned to work in 1980 for a new employer, Salem Memorial Hospital (Salem). In 1983, she began to experience pain and discomfort in her right ankle. By the fall of 1984, her pain was so severe that Dr. Paluska performed an arthrotomy of the ankle. She sought to reopen her original claim against Santiam with Liberty and filed a new claim against Salem with SAIF for an occupational disease. Liberty denied the claim, because it concluded that the ankle condition was not related to the accepted knee conditions. SAIF also denied the occupational disease claim, as did Liberty Northwest Insurance Company, which had assumed coverage for Salem in October, 1984, only four days before claimant's surgery. Claimant requested a hearing on all of the denials.

The referee viewed the issue as one of responsibility and ordered SAIF to accept the claim for payment of compensation. On review, the Board reinstated SAIF's denial and otherwise affirmed, denying claimant any benefits for the ankle condition.

Claimant's first assignment of error is that the Board

erred by not reaching the merits of her claim for medical services against Santiam after it had determined that it lacked jurisdiction to consider her request to reopen her 1976 claim. The Board considered the request as a claim for aggravation and concluded that it lacked jurisdiction, because more than five years had elapsed since the first determination order had issued; it did not consider the claim as one for medical services. We agree with claimant. A claim for medical services is not subject to the five-year limitation on aggravation claims. ORS 656.245(1); *Amlin v. Edward Hines Lumber Co.*, 35 Or App 691, 582 P2d 54 (1978). The Board may have failed to consider the claim as one for medical services because claimant had not given the parties notice of a claim for medical services separate from her request to reopen. At the hearing before the referee, however, the parties stipulated that the only claim that claimant might have against Santiam was for medical services. We therefore decide the merits of that claim.

Santiam argues that, although the 1976 claim was for both knees and the right ankle, it accepted only claimant's knee conditions. We need not decide that issue. There is sufficient evidence in the record to support a relationship between the need for ankle surgery and the compensable condition of the knees. Claimant testified that when she walked she felt a "twisting" in her right knee, which caused her knee to bend in each time she took a step and caused her ankle to bend out to compensate. The record reveals that she repeatedly complained to her doctor about the effect of the knee rotation on her ankle, beginning as early as 1979. In addition, on July 10, 1985, Paluska reported that the degenerative arthritis in the right knee (a part of the occupational disease which had been

the basis of her earlier compensable claim) caused "a waddling type of gait" and "placed more stress on her ankle" and agreed with a statement in a letter of July 25, 1985, from SAIF's counsel that

> "[t]he degenerative arthritis in claimant's right knee contributed objectively and materially to the need for her right ankle surgery in October 1984."

We conclude that claimant has established that her need for ankle surgery in 1984 was related to her 1976 compensable knee disease and that the treatment was reasonable and necessary. *Matthews v. Louisiana Pacific*, 47 Or App 1083, 615

P2d 1151 (1980); *McGarry v. SAIF*, 24 Or App 883, 547 P2d 654 (1976).

Claimant's second assignment of error, by which she attempts to establish a new claim that an occupational disease has made her pre-existing ankle osteoarthritis disabling, is without merit. She has failed to persuade us that the work conditions at Salem were the major cause of the worsening of her disease. *Dethlefs v. Hyster Co.*, 295 Or 298, 667 P2d 487 (1983); *SAIF v. Gygi*, 55 Or App 570, 639 P2d 655, *rev den* 292 Or 825 (1982).[1]

Reversed as to Santiam Memorial Hospital and remanded with instructions to award benefits for medical services; otherwise affirmed.

[1] Claimant's remaining assignment of error requires no discussion.

IN THE COURT OF APPEALS OF THE STATE OF OREGON

In the Matter of the Compensation of Lawrence N. Sullivan, Claimant.

SULLIVAN,
Petitioner - Cross-Respondent,

v.

BANISTER PIPELINE AM et al,
Respondents - Cross-Petitioners.

(WCB 82-10103; CA A38048)

Judicial Review from Workers' Compensation Board.

Argued and submitted September 15, 1986.

James L. Edmunson, Eugene, argued the cause for petitioner - cross-respondent. With him on the briefs were Christopher D. Moore and Malagon & Moore, Eugene.

Richard W. Davis, Portland, argued the cause and filed the brief for respondents - cross-petitioners.

Before Joseph, Chief Judge, and Newman and Deits, Judges.

NEWMAN, J.

Reversed and remanded on the petition for judicial review with instructions to accept the claim; affirmed on cross-petition.

Deits, J., concurring in part; dissenting in part.

NEWMAN, J.

Claimant petitions for review of an order of the Workers' Compensation Board that denied his aggravation claim for hospitalization and treatment resulting from his attempted suicide. Respondents cross-petition from the portion of the order that granted claimant benefits for his right shoulder condition. On the petition, we reverse; on the cross-petition, we affirm.

Claimant suffered compensable knee and back injuries in September, 1980, when he slipped and fell backward in the bed of a truck. He filed a claim for the injury to his knee. He was awarded temporary total disability and compensation for 15% permanent partial disability of his left leg. In April, 1982, the Board ordered the claim reopened because, when he fell, claimant had also sustained a compensable lower back injury and his knee condition had worsened.

In September, 1982, claimant had shoulder surgery. Dr. Samsell, his orthopedist, had diagnosed his condition as "degenerative arthrosis of the right AC joint, traumatic in origin."[1] On October 29, 1982, the insurer issued a denial, which provided, in part:

> "Since the establishment of your claim, involving your low back and left knee, recent medical information received in this office designates treatment for conditions diagnosed as degenerative arthritis * * * . It is the opinion of Argonaut Insurance Company that [the shoulder condition] and your current need for treatment and time loss did not arise out of nor occur in the course and scope of your employment with Banister Pipeline."

The referee found that "the right shoulder problem is more probably than not related to the on-the-job fall" and set aside insurer's denial. The Board affirmed the referee's decision.

In January, 1983, Dr. Colbach, a psychiatrist, interviewed claimant. His diagnosis was:

> "Alcohol abuse, under control at this time, with recent exacerbation probably due to the industrial injury.

> "Psychogenic pain disorder, moderate, with some unconscious overfocusing on his body and some unconscious exaggeration of the extent of his pain problem, related to his industrial injury.
>
> "Dysthymic disorder (depression), manifested by sleep problems, lack of motivation, overfocusing on himself, related to the industrial injury."

[1] The record is unclear as to how the claim for the shoulder condition came to the insurer.

On October 6, 1983, claimant attempted suicide. The circumstances leading up to that are set out in the referee's order:

> "Claimant's temporary disability was terminated by a Determination Order in August 1983. He is married and has children. In the past claimant and his wife were both employed and it appears they enjoyed the standards and comforts of middle-class America. Claimant has not worked since the injury and his wife stopped working in January 1983 because of her concern for claimant's welfare. From August 1983 on there was no regular family income.
>
> "In October 1983 financial matters weighed heavily on claimant. The day before the suicide attempt claimant went hunting with his sons and although he did not engage in any physical activity, found the outing physically difficult for him. The evening after returning from hunting claimant and his wife quarreled and claimant consumed a quantity of wine. The record reflects that, at least at times, before the injury claimant had drunk to excess. Claimant testified that at the time he felt he was hurting his family worse by being alive and on the morning of October 6, 1983 confronted his wife and took the pills."

In November, 1983, claimant filed an aggravation claim for the hospital expenses and subsequent psychiatric treatment resulting from his suicide attempt.[2] The insurer denied the claim. The referee affirmed the denial. He found that "[t]he industrial injury and its aftermath materially contributed to claimant's mental condition and suicide attempt" but ruled "that its influence did not amount to producing an irresistible impulse and thus * * * the claim is not compensable." The Board affirmed the referee.

In *Scheidmantel v. SAIF,* 70 Or App 552, 690 P2d 511 (1984), we held that an aggravation claim may be based on a claimant's psychological problems that result from a compensable physical injury, even though no physical worsening has occurred. In *Jeld-Wen, Inc. v. Page,* 73 Or App 136, 698 P2d 61 (1985), we stated:

> "A claimant asserting the compensability of a psychiatric condition following an industrial injury must prove by a preponderance of the evidence that the work-related injury was a material cause of the condition, or, if the claimant's mental condition predated the injury, that the injury worsened the preexisting condition." 73 Or App at 139. (Citation omitted.)

Although physical and family problems unrelated to the injury were also factors, Colbach, who diagnosed claimant's depression before his suicide attempt, and Johnson, who treated him for depression afterward, concluded that the compensable injury and its effects were material factors in causing his depression. Johnson also concluded that claimant's depression was a "material contributing factor" in causing his suicide attempt. Dr. Stolzberg, a psychiatrist who saw claimant at the insurer's request, suggested that factors unrelated to the injury caused his depression and suicide attempt. She emphasized his other health problems and financial worries. She also

[2] The referee reserved the question whether claimant was entitled to psychiatric or psychological services related to his industrial injury but not related to the suicide attempt. That question is not presented on review.

emphasized that, before his injury, claimant had a "drinking problem." The record indicates, however, that claimant had no significant problem with depression before the injury, that his financial problems resulted from his inability to work after the injury and that his injury and resulting disability substantially exacerbated any drinking problem that he may already have had. *See Grace v. SAIF*, 76 Or App 511, 709 P2d 1146 (1985).

We agree with the referee's conclusion that claimant's industrial injury was a material cause of his depression and suicide attempt. The depression was an "aggravation" of his compensable injury. The expenses from his resulting suicide attempt, therefore, are compensable, unless ORS 656.156(1) precludes compensability.

ORS 656.156(1) provides:

> "If injury or death results to a worker from the *deliberate intention* of the worker to produce such injury or death, neither the worker nor the widow, widower, child or dependent of the worker shall receive any payment whatsoever under ORS 656.001 to 656.794." (Emphasis supplied.)

In *McGill v. SAIF*, 81 Or App 210, 724 P2d 905, *rev den* 302 Or 461 (1986), we said:

> "[A] worker's suicide resulting from work-related stress which produced a mental derangement that impaired his ability to resist the compulsion to take his own life cannot be said to have arisen from a 'deliberate intention' under ORS 656.156(1)." 81 Or App at 214. (Footnote omitted.)[3]

Accordingly, if claimant's depression was a "mental derangement" that impaired his ability to resist a compulsion to take his own life, his suicide attempt cannot be said to have arisen from a "deliberate intention."

A mental derangement "would not necessarily be restricted to some organic mental disease or defect, for advances in the field of psychiatry bring such afflictions as deep depressive anxiety reactions into the area of brain derangement." *Saunders v. Texas Employers' Ins. Ass'n.*, 526 SW2d 515, 518 (Tex 1975). The evidence establishes that claimant was suffering from a "mental derangement" that

---

[3] In *McGill*, we rejected the "irresistible impulse" test under which a

> " 'suicide is not compensable unless there has followed as a direct result of a work-connected injury an insanity of such severity as to cause the victim to take his own life through an uncontrollable impulse or in a delirium of frenzy without conscious volition to produce death.' " 81 Or App at 213 (quoting 1A Larson, *The Law of Workmen's Compensation* 6-140 § 36.00 (1985).

In substance, *McGill* adopted the rule set forth in *Saunders v. Texas Employers' Ins. Ass'n*, 526 SW2d 515, 517 (Tex 1975):

> "A number of jurisdictions, upon recognizing the advances made by medical science and psychiatry relating to the study of human reasoning and behavior have concluded that a suicide cannot be considered to have been intentionally self-inflicted if, in spite of the fact that the act is a conscious one, the suicide can be shown to have resulted from the deceased's inability to control the impulse to kill himself. * * * [I]f the effects of an injury or its treatment so acts upon the will of the injured workman so that it is not operating independently at the time of the suicide, then the chain of causation would appear to be unbroken and the fact that the decedent knew of the physical consequences of his act would be irrelevant."

McGill declined, however, to adopt *Saunders'* use of the word "impulse," because "'the test should not be concerned with whether the compulsion could be characterized as being abrupt, unpremeditated or violent.' " 81 Or App at 214 n 1 (quoting *Saunders, supra*, 526 SW 2d at 517).

impaired his ability to resist a compulsion to take his own life. Johnson concluded, consistently with Colbach's earlier diagnosis, that, before his suicide attempt, claimant was suffering

from "major depression" or "dysthymic disorder," which he characterized as a "psychiatric problem." He also concluded that the disorder impaired claimant's ability to think rationally and that the suicide attempt was an "impulsive act," which he described as "an act which has very little prior thought given to it and is a result of relatively abrupt and strong urges * * * and thoughts highly influenced by emotional factors." Although the alcohol that claimant consumed[4] also may have contributed to his inability to resist the compulsion, his drinking, as discussed above, was related to his injury and its aftermath. We conclude that the suicide attempt did not arise from a "deliberate intention" within the meaning of ORS 656.156(1). Accordingly, claimant's expenses for hospitalization and treatment resulting from his suicide attempt are compensable.

In their cross-petition, respondents argue that there is insufficient evidence to establish that claimant hurt his shoulder when he fell. We disagree. Samsell, claimant's orthopedic surgeon, stated:

> "There is some discrepancy as to the exact mechanism of (shoulder) injury, and I feel that if he fell directly onto his back, then the likelihood of this being a contributing factor to his AC joint arthritis is insignificant. If he fell and landed directly on his right shoulder or onto an outstretched hand which would generate a force across the AC joint, then I think the likelihood of it contributing to the symptoms in the AC joint is quite substantial and more than 51%."

Claimant could not remember exactly how he landed when he fell, but a co-worker who was an eyewitness testified that "his feet went up, he went back and hit on his back, shoulder and head." He also testified that the bed of the truck was strewn with tools and other objects which claimant's shoulder may have struck when he fell. The co-worker could not remember, however, whether claimant's shoulder actually struck one of those objects.

The referee commented on the testimony of the co-worker:

> "He said claimant hit his head, back and shoulder. the witness also said equipment was strewn on the floor of the truck and it was quite likely claimant struck something when he fell. * * * The witness appeared to me to be an angry but honest person."

We give weight to the referee's determination of witness credibility. *Bloomfield v. National Union Ins. Co.*, 72 Or App 126, 694 P2d 1015 (1985). Samsell's opinion concerning the cause of the shoulder condition, combined with the testimony of the co-worker, established that claimant hurt his shoulder when he fell in the bed of the truck and, therefore, that the injury was compensable.

[4] Claimant had consumed a substantial amount of wine before he attempted suicide, and his blood alcohol level was .12 per cent when he was admitted to the emergency room several hours later.

Reversed and remanded on the petition for judicial review with instructions to accept the claim; affirmed on the cross-petition.

DEITS, J., concurring in part; dissenting in part.

I concur in the majority's conclusion that claimant's shoulder injury is compensable and that his depression was an "aggravation" of his compensable injury. However, because I believe that the majority misapplies ORS 656.156(1) as interpreted by this court in *McGill v. SAIF,* 81 Or App 210, 724 P2d 905, *rev den* 302 Or 461 (1986), I dissent from the holding regarding the suicide attempt.

My principal concern is that the majority has modified the causation principles articulated in *McGill.* It is my understanding, based on the language of the statute as well as this court's decision in *McGill* that, in order to avoid the limitation of compensation in ORS 656.156(1), the underlying compensable injury and the conditions resulting therefrom must be the *primary cause* of the mental derangement which impaired the ability to resist the compulsion to take one's own life. The majority decision relaxes the standard in *McGill* and requires only that the injury be a material factor in causing the mental derangement.

McGill involved the suicide of a physician, caused by a compensable occupational depressive disorder which resulted from two medical malpractice actions that had been filed against him. Before the actions, he had been a respected physician in the Portland medical community. There was no evidence or contention that non-employment influences or pre-existing conditions caused his depression. We stated:

> "We hold that a worker's suicide resulting from work-related stress which *produced* a mental derangement that impaired his ability to resist the compulsion to take his own life cannot be said to have arisen from a 'deliberate intention.' " 81 Or App at 214. (Footnote omitted; emphasis supplied.)

"Produce" means "to cause to have existence or to happen." *Webster's Third New International Dictionary* (1976). In *McGill,* the work-related disorder was the sole and exclusive cause of the decedent's derangement. I believe *McGill* requires that the underlying injury to be the primary cause of the derangement.

The facts of this case are in marked contrast to *McGill.* Here, claimant had a large number of physical and emotional problems that pre-dated the compensable injury. Approximately six months before the injury, he was involved in an automobile accident in which he lost an ear. He had a history of alcohol abuse; his wife stated that he had always been a heavy drinker. He had had several operations to correct circulatory problems. There were many problems within his family. In short, he was a troubled man before the industrial accident.

The psychiatric experts who examined him agreed that the compensable injuries contributed to the depression which led to his suicide attempt but that other factors—most notably pre-existing problems with family, health and alcohol—were also contributing factors. Dr. Colbach indicated: "Some of [claimant's distress] can be attributed to the indus-

trial injury, but some of it seems to predate this and be due to other factors." Dr. Johnson believed that the depression and intoxication were the two major factors that led to his suicide attempt. Dr. Stolzberg did not directly relate the suicide attempt to the industrial injury. Those opinions indicate that the causal relationship between the injury and the suicide attempt required by *McGill* has not been met.

In this case, the work-related disorder was but one of several factors contributing to claimants' depression. The referee correctly concluded:

> "Both [psychiatrists Johnson and Stolzberg] indicate that to some degree the injury and its aftermath including the physical condition and discomfort, the resulting unemployment and strained financial circumstances, and the termination of

> compensation played *some role* in claimant's mental state and suicide attempt. Other life circumstances including non injury-related physical problems also weighed on claimant's mind." (Emphasis supplied.)

The facts indicate that the compensable injury was a factor contributing to, but was not the primary cause of, his mental condition, as *McGill* requires. Therefore, I would conclude that the medical expenses associated with the suicide attempt are noncompensable. Accordingly, I disagree with the majority's contrary holding.

IN THE COURT OF APPEALS OF THE STATE OF OREGON

In the Matter of the Compensation of Richard A. Johnson, Claimant.

JOHNSON,
Petitioner,

v.

CITY OF ROSEBURG et al,
Respondents.

(WCB No. 84-00831; CA A38383)

Judicial Review from Workers' Compensation Board.

Argued and submitted December 17, 1986.

Linda Love, Portland, argued the cause for petitioner. On the brief was Peter W. McSwain, and Francesconi & Cash, P.C., Portland.

Darrell E. Bewley, Assistant Attorney General, Salem, argued the cause for respondents. With him on the brief were Dave Frohnmayer, Attorney General, and Virginia Linder, Solicitor General, Salem.

Before Richardson, Presiding Judge, and Newman and Deits, Judges.

NEWMAN, J.

Reversed and remanded with instructions to reinstate referee's order.

NEWMAN, J.

Claimant seeks review of a Workers' Compensation Board order that denied his occupational disease claim. We reverse. Claimant, age 46, was a fire fighter for 23 years with the City of Roseburg. He worked as an engineer during the last 10 years of his employment, but he continued to go out on fire calls. He has averaged one fire call every two-and-one-half weeks. He used primitive respiratory equipment during the early years of his fire fighting. He would frequently remove his mask during the clean-up phase of a fire to obtain better visibility. On many occasions, after fighting a fire, he would cough up black sputum for several days. He has smoked from one to two packs of cigarettes a day since he was 14 or 15 years old.

In February, 1980, claimant had an x-ray which showed that he did not have lung cancer, but in November, 1983, Dr. Bilder diagnosed squamous cell carcinoma of the left lung. Claimant underwent a left pneumonectomy and subsequently received chemotherapy. In January, 1984, SAIF denied his claim for left lung cancer. In December, 1984, the referee set aside SAIF's denial:

> "From the evidence presented, I find that it is medically probable that the major contributing cause of the claimant's lung cancer was voluntarily ingested cigarette smoke. However that is not the test in this case. The test in this case is whether SAIF has shown by clear and convincing evidence that claimant's work exposure did not contribute to the cancer. This SAIF has failed to do. Therefore the claim is compensable."

The Board reversed and reinstated the denial:

> "[W]e are convinced that SAIF has shown that it is highly probable that employment exposure to smoke and other byproducts of combustion in the course of claimant's employment did not contribute to claimant's disease. Therefore, we find the evidence is clear and convincing that claimant's occupational exposure to byproducts of combustion did not contribute to the cause of his lung cancer. Accordingly, we reverse the Referee's order."

ORS 656.802 provides, in part:

> "(1) As used in ORS 656.802 to 656.824, 'occupational disease' means:

> "* * * * *
>
> "(b) Death, disability or impairment of health of fire fighters of any political division who have completed five or more years of employment as fire fighters, caused by any disease of the lungs or respiratory tract, hypertension or cardiovascular-renal disease, and resulting from their employment as fire fighters.
>
> "(2) Any condition or impairment of health arising under paragraph (b) of subsection (1) of this section shall be presumed to result from a fire fighter's employment. However, any such fire fighter must have taken a physical examination upon becoming a fire fighter, or subsequently thereto, which failed to reveal any evidence of such condition or impairment of health which preexisted employment. Denial of a claim for

any condition or impairment of health arising under paragraph (b) of subsection (1) of this section must be on the basis of clear and convincing medical evidence that the cause of the condition or impairment is unrelated to the fire fighter's employment."

Claimant has established the facts which give rise to the presumption that his cancer results from his employment. ORS 656.802(1)(b)(2).[1] SAIF, therefore, must produce clear and convincing medical evidence that the cause of the cancer is "unrelated" to his employment. *See Wright v. SAIF*, 289 Or 323, 332, 613 P2d 775 (1980).

Although we do not agree with the Board's conclusions about the medical evidence, it accurately summarized the content of that evidence:

"Dr. Gordon, the thoracic surgeon who performed claimant's pneumonectomy, opined that exposure to fire smoke had not been shown to be a significant cause of lung cancer and that claimant's condition was due to his cigarette smoking. Dr. Shafer, the radiation oncologist who treated claimant after surgery, opined that it was conceivable that claimant's occupation contributed to his condition as compared to his

cigarette smoking exposure. Dr. Bilder, the pulmonary specialist who diagnosed claimant's lung cancer and who had four years experience as a volunteer fireman, reported that he had never seen the type of cancer that claimant had in a person who did not smoke cigarettes and opined that claimant's cancer was due to cigarette smoking. Dr. Hansen, the pulmonary specialist who examined claimant for the insurer, opined that claimant's squamous cell cancer was due to cigarette smoking and was not related to his occupation. Dr. Bendix, who holds a Ph.D. in physiochemical biology with a special interest in toxic substance exposures and who reviewed claimant's medical reports, opined that claimant's occupation had caused him additional unprotected exposure to carcinogenic byproducts of combustion and that his occupation had, therefore, contributed to the causation of his lung cancer."

The opinions of Gordon and Shafer indicate that claimant's employment may have contributed to his lung cancer and, accordingly, are not evidence that the cause of his cancer was "unrelated" to his employment. Moreover, Bendix's report, which includes an analysis of specific carcinogenic substances to which claimant was actually exposed at various fires, concluded that "[i]t is probable that [claimant's] professional work caused or at least contributed to his lung cancer."

Although Bilder and Hansen assert that claimant's employment was not a causal factor, their opinions are based primarily on a report by an industrial hygienist for SAIF. That report summarizes the results of several studies on the rela-

[1] Claimant established that (1) he has a "disability or impairment of health," ORS 656.802(1)(b); (2) he was employed as a fireman of a political division; (3) he has completed more than five years of employment in that capacity; (4) a disease of his lungs caused his disability or impairment; and (5) he had had a physical examination subsequent to his becoming a fire fighter "which failed to reveal any evidence of such condition of impairment of health which preexisted [his] employment." ORS 656.802(1)(b).

tionship between fire fighting and lung disease.[2] None of those studies, with the possible exception of a study of Boston fire

fighters, concludes that fire fighting is unrelated to lung cancer. Bendix's report[3] questions the methodology and conclusions of the Boston study.

SAIF has failed to produce clear and convincing evidence that the cause of claimant's lung cancer is unrelated to his employment.

Reversed and remanded with instructions to reinstate referee's order.

---

[2] The report, prepared by a person named Natsch, included this summary:

"1. The mortality experience of 5655 Boston fire fighters since 1915 was examined. The standard mortality rate for neoplastic deaths (cancer) was 83%. In other words, it was below the expected rate for the general population.

"2. A study of 193 subjects of the New South Wales Fire Brigade concluded that the major combustion products responsible for respiratory damage were self-administered, arising from burning tobacco rather than from burning buildings.

"3. A study of pulmonary function of 54 fire fighters from Connecticut concluded that cigarette smoking appeared to be a major contributor to obstruction of airways in fire fighters.

"4. A 1982 article suggests that fire fighters are at a higher risk of suffering some decrease in pulmonary function. However, evaluation of data suggests that smokers, regardless of occupation, are at a greater risk."

[3] Bendix's comments are:

"[Natsch's report] lists products of combustion found in cigarette smoke, including vinyl chloride, acrylonitrile, benzol(a)pyrene and cadmium. Fire fighter exposure to these substances was documented in my original report on the subject case. Many of the substances listed for the particulate phase are polyaromatic hydrocarbons expected to be present whenever something organic burns, i.e., at virtually every fire of every type. The chemistry of cigarette smoke has been more intensively studied than any other smoke. There is no reason to expect more carcinogens in cigarette smoke than in other smokes. A fire fighter who is a heavy cigarette smoker has still received a heavier work smoke carcinogen exposure during his fire fighting career. The occupational exposure is therefore a more probable cause of his lung cancer than his cigarette smoking."

As to the Boston study, she states:

"This study was not designed to reveal whether a 'healthy worker effect' exists for cancer in fire fighters. Fire fighter mortality was compared to the mortality of all Massachusetts and all U.S. males rather than to a control group of healthy workers. The studies I have cited suffer the same methodological fault but reveal differences large enough to be statistically significant without taking the healthy worker effect into account. Another Boston study is underway, and I understand that preliminary results indicate a significant increase in cancer incidence in fire fighters since World War II. Another reason not to apply the Musk *et al.* study is that building materials in Boston and on the Pacific Coast differ due to differences in climate and in the average age of buildings. This would be responsible for significant differences in the combustion products fire fighters experience. I would expect that California exposures would be more relevant to Oregon experience than those of Massachusetts."

IN THE COURT OF APPEALS OF THE
STATE OF OREGON

In the Matter of the Compensation of
Steven Stedman, Claimant.

STEDMAN,
Petitioner,

v.

SAIF CORPORATION et al,
Respondents.

(WCB No. 85-07815; CA A39522)

Judicial Review from Workers' Compensation Board.

Argued and submitted December 5, 1986.

Peter Fahy, Eugene, argued the cause for petitioner. On the brief was Steven C. Yates, Eugene.

Christine Chute, Assistant Attorney General, Salem, argued the cause for respondents. With her on the brief were Dave Frohnmayer, Attorney General, and Virginia L. Linder, Solicitor General, Salem.

Before Richardson, Presiding Judge, and Newman and Deits, Judges.

PER CURIAM

Affirmed.

PER CURIAM

Claimant seeks review of an order of the Workers' Compensation Board that affirmed the referee's award of 75% permanent disability. He asserts that he is permanently and totally disabled. In 1983, claimant, then age 24, sustained a lumbar strain when he fell off a log while working as a choker setter. He is unable to return to heavy labor, which has been his only type of work experience. He is of limited intellectual capability and can neither read nor write. He has twice been referred to vocational training programs. He failed to report for scheduled appointments and to cooperate in attempts to rehabilitate him. On the basis of the record, we do not agree with claimant that an attempt at vocational rehabilitation would be futile. The Board correctly affirmed the referee, who concluded that claimant has not sustained his burden to prove that he has made reasonable efforts to obtain employment. *See* ORS 656.206(1), (3).

Affirmed.

IN THE COURT OF APPEALS OF THE STATE OF OREGON

In the Matter of the Compensation of Delbert E. Norton, Claimant.

NORTON,
Petitioner,

v.

SAIF CORPORATION et al,
Respondents.

(WCB 82-04904; CA A41192)

Judicial Review from Workers' Compensation Board.

Argued and submitted June 1, 1987.

Robert K. Udziela, Portland, argued the cause for petitioner. With him on the brief were David A. Hytowitz, Portland, and Pozzi, Wilson, Atchison, O'Leary & Conboy, Portland.

Darrell E. Bewley, Assistant Attorney General, Salem, argued the cause for respondents. With him on the brief were Dave Frohnmayer, Attorney General, and Virginia L. Linder, Solicitor General, Salem.

Before Warden, Presiding Judge, and Van Hoomissen and Rossman, Judges.

VAN HOOMISSEN, J.

Reversed; referee's order reinstated.

VAN HOOMISSEN, J.

Claimant seeks review of a Workers' Compensation Board order reducing his permanent total disability award to 50 percent unscheduled permanent partial disability.[1] He contends that the Board erred in concluding that he is no longer totally disabled. We reverse.

Claimant sustained a compensable injury to his back in 1968 while working on the green chain. He was awarded permanent total disability in 1971. In April, 1981, the Evaluation Division found no change in his status and ordered that his permanent total disability benefits continue. In September, SAIF requested another reevaluation. The Division again found no change and ordered that his permanent total disability benefits continue.

In April, 1982, claimant was examined, at SAIF's request, by Dr. Cramer at the Northwest Pain Center. Cramer

[1] ORS 656.206(1)(a) provides:

" 'Permanent total disability' means the loss, including preexisting disability, of use or function of any scheduled or unscheduled portion of the body which permanently incapacitates the worker from regularly performing work at a gainful and suitable occupation. As used in this section, a suitable occupation is one which the worker has the ability and the training or experience to perform, or an occupation which the worker is able to perform after rehabilitation."

reported that claimant "will continue to exhibit himself as a totally and permanently disabled person. It is unlikely that any form of medical treatment would significantly alter his current condition." Northwest Pain Center's multidisciplinary team reported, *inter alia,* that claimant exhibited a great deal of subjective pain, that his physical findings do not corroborate the level of pain, that he is of borderline to low average intelligence and is illiterate, that he and his wife are committed to his role as a disabled individual and that it is unlikely that he would ever give up that role. The staff concluded, in relevant part:

> "On objective grounds, [claimant] is not totally and permanently disabled on a physical basis, although he sees himself as totally and permanently disabled and it is our feeling that he intends to remain that way."

On May 19, a determination order issued, which stated:

> "The Department now finds that you are no longer permanently and totally disabled, and that you are entitled to no award of permanent partial disability."

That order was based on all the medical reports generated in the claim and on surveillance films of claimant. Claimant requested a hearing.

In April, 1983, SAIF referred claimant to Dr. Olmscheid. He reported that it is difficult to examine claimant due to "severe functional disturbance" and that that condition has been noted in his records since the late 1960's. He concluded that claimant's condition had not changed significantly since 1969. He seriously doubted that claimant "could be gainfully employed in any variety of substantial or suitable work." In October, a vocational rehabilitation consultant reported that claimant was 63 years old, had a third grade education and was illiterate, that his previous work roles relied on physical strength, that he could not be expected to return to work and that new skills training was not feasible.

The referee viewed three reels of film taken between November, 1981, and May, 1982.[2] They revealed that claimant could walk, drive a motor vehicle and spend 18 minutes mowing his law. The referee stated, in relevant part:

> "While it is obvious that claimant does not always use a cane as he indicated to the examiners at Northwest Pain Center, I am not persuaded that this fact nor the level of activity exhibited by claimant in the films would enable him to suddenly be gainfully and suitably employed.
>
> "There is no indication that his IQ has been elevated above its 1960's level. There was introduced no evidence which would indicate claimant was less illiterate now than in 1971 or November of 1981. There is no evidence that his stamina would allow him to work all day long. Indeed at times it seemed he was locked in mortal combat with his lawn mower and that at any time he was sure to succumb.
>
> "He is, however, about 13 years older. Between temporary disability payments and permanent disability payments,

[2] *See* ORS 656.206(5). The referee considered only those films made before May 19, 1982, the date of the determination order. He refused to consider any subsequent films. The Board concluded that, because disability is rated as it exists at the time of the hearing, *see Gettman v. SAIF,* 289 Or 609, 614, 616 P2d 473 (1980), all of the films could be considered. We agree with the Board.

claimant has been dependent upon workers' compensation from about age 48 to age 64; 16 years; one-quarter of his life."

The referee concluded:

"I am persuaded by the evidence as a whole that claimant was as permanently and totally disabled when the permanent total status was revoked, if not more so, than when the permanent total disability status was first granted, and certainly as disabled as he was in November 1981 when his permanent total disability status was reaffirmed by the Evaluation division."

On review, the Board stated, in relevant part:

"On this entire record, we conclude that SAIF has not proved that claimant's medical condition has improved since he was awarded compensation for permanent total disability in 1971. SAIF's position, therefore, may only prevail if it has proved by a preponderance of the evidence that claimant is employable."[3]

Notwithstanding, the Board was impressed with SAIF's surveillance films:

"Contrary to claimant's statements reported in the medical and vocational documents that he always must use a cane or crutches to walk, that he had not driven a motor vehicle in over 13 years and that he can perform almost no physical activity due to disabling pain, are the surveillance films. These films show claimant walking without a cane, including walking up the steps to his home, driving his car, mowing his lawn, including an embankment, with a push mower, pushing and pulling a tent trailer, working in his yard and lifting and carrying boxes of building materials estimated to weigh at least 50 pounds each. Claimant was shown engaging in all of these activities without apparent discomfort.

"We conclude that the surveillance films represent persuasive circumstantial evidence that claimant is capable of performing some gainful and suitable employment that would include walking, standing, stooping, bending, pushing, pulling, climbing stairs and lifting and carrying objects weighing

up to 50 pounds. This circumstantial evidence was not controverted at the hearing. Claimant did not appear or testify at the hearing. Any inference that the activities claimant is shown engaging in may have caused periods of increased disability or required long periods of rest is simply not supported by any evidence in the record. We conclude that SAIF has proved by a preponderance of the evidence that claimant is currently capable of performing some work at a gainful and suitable occupation. He is, therefore, not permanently and totally disabled."

The Board found that claimant had sustained a loss of earning capacity due to his industrial injury and should be awarded 50 percent unscheduled permanent partial disability. One member dissented. He concluded that, although the films demonstrated that claimant can do several things which he stated

[3] We agree with SAIF that "it is not required to prove that claimant's medical condition has improved since he was awarded compensation for permanent total disability in 1971." ORS 656.206 only requires a determination as to whether claimant is currently incapacitated from performing work at a gainful and suitable occupation. That may be indicated either by proof of improvement in the claimant's medical condition or by evidence of employability. *See Kytola v. Boise Cascade Corp.*, 78 Or App 108, 111, 714 P2d 1083, *rev den* 301 Or 765 (1986).

that he could not do, they do not demonstrate that he is able to perform a gainful and suitable occupation.

The determination of permanent total disability status turns on "whether the claimant is currently employable or able to sell his services on a regular basis in a hypothetically normal labor market." *Harris v. SAIF,* 292 Or 683, 695, 642 P2d 1147 (1982). Because SAIF is attempting to terminate or modify claimant's award, it has the burden of proving "a change of circumstances sufficient to warrant the relief sought." *Harris v. SAIF, supra,* 292 Or at 690; *Kytola v. Boise Cascade Corp., supra* n 3, 78 Or App at 111; *Bentley v. SAIF,* 38 Or App 473, 590 P2d 746 (1979).

SAIF contends that its evidence shows that claimant is able to engage in activities that he claimed that he could not do, walk without a cane or crutches, bend, stoop, push, pull or lift, drive a car and dress and undress himself. However, that evidence does not establish that he is currently employable or that he will be able to sell his services on a regular basis in a hypothetically normal labor market. *See Petz v. Boise Cascade Corporation,* 58 Or App 347, 648 P2d 372, *rev den* 293 Or 521 (1982). Claimant is now 67 years old. He has been disabled since 1968. He has a third grade education and is functionally illiterate. He has a work history of unskilled or semi-skilled heavy physical labor. It is unlikely that he can be trained to acquire new skills.

The Board concluded that SAIF had not proved that

claimant's medical condition had improved since he was awarded compensation for permanent total disability in 1971. Notwithstanding that, the Board was persuaded by SAIF's surveillance films. The level of activity shown in SAIF's films does not persuade us that claimant is able to return to work. On *de novo* review, ORS 656.298, we conclude that SAIF has not proved that claimant is currently employable or that he is able to sell his services on a regular basis in a hypothetically normal labor market and that the Board erred in reducing claimant's permanent total disability award.

Reversed; referee's order reinstated.

IN THE COURT OF APPEALS OF THE
STATE OF OREGON

In the Matter of the Compensation of
Michael P. Dundon, Claimant.
MISSION INSURANCE COMPANY et al,
Petitioners,
v.
DUNDON et al,
Respondents.
(84-08785 and 84-08786; CA A40182)

On Judicial Review from Workers' Compensation Board.

Argued and submitted April 10, 1987.

Marianne Bottini, Portland, argued the cause for petitioners. With her on the briefs was Bottini, Bottini & Lehner, Portland.

H. Scott Plouse, Medford, argued the cause and filed the brief for respondents Crawford Logging and Loggers Assurance Company.

No appearance for respondent Dundon.

Before Warden, Presiding Judge, and Van Hoomissen and Young, Judges.

YOUNG, J.

Reversed; referee's order reinstated.

YOUNG, J.

Mission Insurance Company (Mission) and Wood Contractors (Wood) seek review of a Workers' Compensation Board order holding them responsible for claimant's right knee injury. The issue is whether claimant suffered an aggravation (the responsibility of Mission and Wood) or a new injury (the responsibility of Loggers Assurance Company (Loggers) and Crawford Logging (Crawford)). We hold that Loggers and Crawford are responsible and reverse.

Claimant was originally injured on February 25, 1984, while employed by Wood. He was attempting to negotiate a rock face when he slipped and fell down a slope, striking the outside of his right knee on a rock. Although claimant managed to finish the day's work, the pain in his knee convinced him that he needed to see a doctor. He first saw Dr. Ross, who referred him to Dr. Schachner, an orthopedic surgeon. On March 21, Schachner examined him, suggested resistive and limbering exercises and gave him a tentative work release date of March 26.

On March 26, claimant went to work for Crawford. On April 11, he again hurt his right knee when he jumped to the ground from a caterpiller tractor. His original injury caused problems on the outside side of his right knee. Those complaints had not completely resolved by the time of the Crawford incident. After the second fall, claimant had new

complaints on the inside of his right knee, in addition to a worsening of pain on the outside of the knee.

Mission and Crawford denied responsibility. The referee ruled that the second injury "constitutes a new and intervening injury which absolves the original carrier from further responsibility for either the ongoing lateral right knee problems or ongoing medial right knee problems." The Board reversed, holding that claimant had suffered an aggravation which was the responsibility of Mission. On *de novo* review, we agree with the referee.

In successive injury cases, the first employer remains responsible if the second injury takes the form of a recurrence of the first and the second incident did not contribute to the causation of the disabling condition. If, on the other hand, the second incident independently contributed, however slightly,

to the causation of the disabling condition, the second employer is solely responsible.[1] *Boise Cascade Corp. v. Starbuck*, 296 Or 238, 244, 675 P2d 1044 (1984); *Hensel Phelps Const. v. Mirich*, 81 Or App 290, 294, 724 P2d 919 (1986). In his deposition, Schachner testified:

> "Q: All right, and in your opinion, he sustained an injury on [April 11, 1984,] different in nature than the condition he presented on March 26, 1984?
>
> "A: I felt he had new components to the injury as well as components related to the previous injury.
>
> "Q: All right. Given the mechanism of injury he indicated to you * * * would what he said occurred in and of itself constitute an injury even if in the absence of the February incident?
>
> "A: That has always been my point that I felt that the mechanism sustained in April was sufficient force to generate a series of complaints independent of the February injury.
>
> "* * * * *
>
> "Q: Did the April [11], 1984, injury contribute, in your opinion, to the outside strain as well as to the injury?
>
> "A: Yes.
>
> "Q: It contributed independently?
>
> "A: Independently and as a source of aggravation."

That uncontroverted testimony establishes that the second injury both aggravated the old injury *and* contributed independently to claimant's right knee condition. Because even the slightest independent contribution is sufficient to shift responsibility to Crawford and Loggers, the Board erred in reversing the referee.[2]

Reversed; referee's order reinstated.

---

[1] This is the last injurious exposure "rule of liability," which avoids the difficult and often impractical task of allocating responsibility between two or more partially liable employers. There is also a "rule of proof," which is not involved in this case. *See Bracke v. Baza'r*, 293 Or 239, 246, 646 P2d 1330 (1982); *see also Runft v. SAIF*, 303 Or 493, ___ P2d ___ (1987).

[2] The Board apparently believed that the contribution had to be material. However, *Boise Cascade v. Starbuck, supra*, makes it clear that *any* contribution, however slight, suffices to shift responsibility to the second employer.

IN THE COURT OF APPEALS OF THE
STATE OF OREGON

In the Matter of the Compensation of
Danny H. Collins, Claimant.

COLLINS,
Petitioner,

v.

HYGENIC CORPORATION OF OREGON et al,
Respondents.

(WCB No. 85-00760; CA A39404)

Judicial Review from Workers' Compensation Board.

Argued and submitted December 17, 1986.

Ralph M. Yenne, Salem, argued the cause for petitioner. On the brief were Charles D. Maier, and Gatti, Gatti, Maier, Smith & Associates, Salem.

John A. Reuling, Jr., Assistant Attorney General, Salem, argued the cause for respondents. With him on the brief were Dave Frohnmayer, Attorney General, and Virginia L. Linder, Solicitor General, Salem.

Before Richardson, Presiding Judge, and Newman and Deits, Judges.

NEWMAN, J.

Reversed and remanded with instructions to accept claim.

NEWMAN, J.

Claimant seeks review of an order of the Workers' Compensation Board that affirmed the referee and denied his claim for medical services.[1] We reverse.

Claimant worked as a "snorkel bender." He sprayed cut plastic tubing with an aerosol lubricant, placed it in a metal mold, put the mold in an oven to bake and subsequently removed the mold from the oven and the tubing, or snorkel, from the mold. He worked on the mezzanine above the first floor of the building. Employer changed the lubricant to a silicone product containing 1,1,1 trichloroethane (3 TCE). Claimant and a co-employe started to use that spray on a Monday. During that work week, claimant was frequently exposed to the spray. By Wednesday night, after he had left work, he noted irritation at the back of his throat and upper chest and labored breathing. Claimant testified that, by Thursday, "I felt like there was a — a numbness in top of my lungs here right before I went to work — or right before I got off work." On Thursday night he decided "I was gonna quit 'cause I thought my health was in jeopardy. So I announced to them Friday when I went in to pick up my check that I was quitting."

[1] The charges were $100.

On the following Tuesday, claimant went to see Dr. Shultz, an internist and specialist in pulmonary diseases. Shultz reported:

> "The history obtained is certainly compatible with significant occupationally associated airway irritation of both upper and lower respiratory tracts. * * * It is conceivable that inhalation of an aerosol of this chemical could cause local airway irritation. Alternatively, the product when heated and vaporized might break down into other toxic gases causing airway irritation. There is no evidence * * * that this patient has sustained injury anatomically or physiologically to the lungs. However, in view of the severity of the symptoms, I would agree that a return to this work environment is ill advised. It is my opinion that this product should probably not be used due to the irritant effect of the Trichloroethane or that better ventilation of the facility should be provided.
>
> "RECOMMENDATIONS: The patient is reassured as

> to the probable transient nature of his persisting respiratory symptoms. I have asked him to return if he continues to have respiratory difficulty, but have advised that he not return to this work environment as long as the current product is being utilized. I will attempt to contact his employers and advise them of the possible toxicity of this product. No return appointment is scheduled at this time."

Claimant did not return to Shultz for further treatment.

Subsequently, Shultz wrote to claimant's attorney:

> "Specifically, I agree that [claimant's] inhalation exposure at Hygenic Corporation was probably the direct cause of his respiratory symptoms prior to the time he came to my office for evaluation. One of the constituents of the silicone spray used as a lubricant in the process of making snorkels was trichloroethane, a chemical which can be quite irritating to the airways of susceptible individuals. I suspect the heating process used in manufacturing the snorkels liberated considerable quantities of this product into the atmosphere. Although I did not personally inspect Mr. Collins' work place it is my understanding that the ventilation system was not exhausted to the outside of the building in his immediate area of exposure."

Shultz testified that he had based his initial opinion "totally" on the accuracy of what claimant had told him. He also testified:

> "The extent of my contact with regard to this product was I did call the Poison Control Center in Portland after I saw [claimant], and I asked them to look up in their records what this product was and what effects it could have.
>
> "And I was advised that when aerosolized, this product could be irritating to the mucous membrances, which corresponded to my recollection of chlorine molecule products and confirmed my suspicion that this could be a factor contributing to his symptoms.

He testified further:

> "[Claimant's] sensitivity to whatever was in his work environment atmosphere was probably an idiosyncratic type of reaction. * * * He might have sensitivity to a very minute quantity of this product, whereas other individuals might have a very low responsiveness to that type of product.
>
> "* * * * *

> "* * * [T]here is a spectrum of sensitivity in all industrially associated product exposure. * * * [T]here are a number of products which were considered to be in safe concentrations in years past which have subsequently been found to cause sensitivity in a certain number of individuals in the workplace.
>
> "And while I would say that those standards are based on some objective data of which I am not aware, I think that there may be exceptions to that and it wouldn't necessarily convince me that his symptoms were unrelated to that."

In reply to a question whether he had made a "definite diagnosis," he stated:

> "I think no diagnosis can be made without definite objective date to support that diagnosis. What I indicated was a high clinical suspicion that something in the patient's environment, in his workplace, was responsible for his symptoms. And based on the information I have, the most likely irritant was the trichloroethane spray used by him and his coworker."

Claimant argues that he established that his exposure to 3 TCE was the major contributing cause of his need for Shultz's services. Insurer responds that claimant did not establish that he suffered an injury and, in any event, that he did not sustain his burden to show that his exposure to 3 TCE caused his symptoms. If claimant suffered the symptoms which he described, and if his exposure to 3 TCE was their major contributing cause, the medical services which Shultz performed were "required," even though Shultz found no objective evidence of the symptoms.[2] *See* ORS 656.005(8)(a).[3]

The referee, in affirming insurer's denial, relied on the report and testimony of the insurer's industrial hygienist, Natsch, who had monitored claimant's co-employe when he was working alone in the workplace. Natsch reported:

> "The results indicated extremely low levels of 1,1,1-trichloroethane; 5.6 ppm compared to the Oregon Permissible Exposure Limit of 350 ppm.

> "The physician was also concerned that the heating of the spray and thermal decomposition products could be harmful. This does not appear likely since the oven is kept at a very low heat (180-220°). Temperatures in this range could cause faster volatilization. Higher temperatures would burn the plastic. Regardless the employee is nowhere near the oven during the heating cycle."

He testified that 3 TCE "could be considered a toxic substance" and that its vapors can be harmful "at levels that would be recognized to be harmful." In answer to the question whether the toxic properties of 3 TCE could cause respiratory irritation, he testified:

> "There's some bit of debate on that also, and the reason I say that in reviewing toxicology literature that's available in our library, the mention of acute effects as far as the symp-

[2] The referee stated:

"I do not think a viable Workers' Compensation claim can be established where there is no diagnosis and no symptoms upon medical examination."

[3] Insurer cites *Brown v. SAIF*, 79 Or App 205, 717 P2d 1289, *rev den* 301 Or 666 (1986), but there the claimant suffered no symptoms.

tomatology of acute exposure to the substance mentioned items of eye irritation and skin irritation, but there was no specific mention of respiratory irritation as far as acute effects, except in the fact of fairly high exposures where it might be related to a central nervous system effect that would effect the respiratory system."

He stated that the American Conference of Governmental Hygienists, which publishes "allowable limits in the workplace," are "not saying that [350 parts-per-million] is a safe level for everyone. * * * [T]he 350 part-per-million recommendation that they make is set to avoid irritation."

Natsch could not recall whether the windows "alongside the mezzanine room were 'openable' " during the tests that he had run with the co-employe.[4] He gave a carefully qualified answer to the question whether the oven emitted vapors and testified that he "wouldn't expect high levels." He stated that "as far as background levels in the room, I would expect that they would be very low." He testified that employer discontinued using 3 TCE after claimant quit, because "they were concerned if somebody could possibly have a problem with it that they would quit using it."

The referee discounted Shultz's report and testimony for several reasons. Shultz believed that vaporized gases emitted from the oven when it was opened were the most likely cause of claimant's symptoms. The referee found that no vaporized fumes were emitted from the oven "based on the test and testimony of [Natsch] that claimant would probably not be exposed to any residual spray when he unloaded the oven." Natsch's testimony, however, does not support that conclusion. Moreover, Shultz testified:

"And whether there was product in the oven, meaning trichloroethane concentration in the oven, would be not important to me because he didn't work in the oven. But if he worked in the area where these nozzles were, where these snorkels were cooling, or in an area where the exhaust from that oven vented, then I would be concerned about the concentrations there.

"But basically we're talking about theoretical data, I think, and that is whether the individuals who formed the group upon which the standard was based are the same as [claimant] in terms of their sensitivity."

The referee believed that claimant had been inaccurate in describing to Shultz "the degree of ventilation in the mezzanine area where claimant worked"[5] and observed that Shultz had not visited the workplace. It is not clear from the record, however, to what extent claimant's explanation to Shultz of the ventilation was inaccurate.[6] Claimant had been

[4] Employer testified that the windows open into the main part of the plant. Claimant testified that the windows did not open.

[5] Shultz testified:

"My understanding from the comments that were made by [claimant] at the time I saw him were [sic] that those rooms did have windows, but the windows were not open. That there were fans in the room which circulated the air, but the air was not exhausted to the outside of the building."

[6] Shultz testified:

"My understanding was that he worked on a second floor in a metal building with one other employee in an area that had no open window ventilation or any active exhaust system from that work area.

"* * * * *

"I think the fact that it, the area was not, to my understanding, optimally ventilated for exposure to aerosolized or vaporized products would contribute to the probability that his symptoms were associated with one of these products."

inaccurate in reporting to Shultz that his co-employe had suffered some symptoms from exposure to 3 TCE. Insurer's counsel, however, questioned Shultz about the significance of "a co-worker having some effects." Shultz responded:

> "[T]here are some compounds which are irritating to virtually all individuals. There are other compounds which are irritating only to hypersensative individuals.

> "And he felt that his co-worker had had some adverse side effects, but he was not able to define exactly those side effects or if he, as I recall, he did not describe them as identical to his side effects."

Furthermore, although Shultz had no experience with 3 TCE, Natsch conceded that the chemical is toxic.

We do not agree with the referee that Shultz's testimony was "unimpressive" or that it represented a significant "erosion" of his report. We also do not agree that Shultz's report that "it is conceivable" that 3 TCE could cause local airway irritation materially reduces the effect of his concluding testimony that

> "based on the information I have, the most likely irritant was the tricholoroethane spray used by him and his co-worker."

We are persuaded by claimant's testimony that he did suffer the symptoms that he described after his exposure to 3 TCE. It is not critical whether the vapors came principally from the oven or from spraying or from drying of the snorkels after they were taken from the oven or were simply part of the background levels in claimant's work area. It is undisputed that 3 TCE is toxic and that employer ceased to use it after the incident involving claimant. Moreover, Natsch recognized that, although claimant's exposure to 3 TCE was well below recognized safety levels, those levels were not necessarily safe for everyone.

We believe that the referee gave undue weight to Natsch's testimony. Schultz's opinion that exposure to 3 TCE was the probable cause of claimant's symptoms is persuasive. An entirely reasonable explanation, on this record, is that claimant is more susceptible than most people to 3 TCE and that his exposure on the job caused his symptoms. He was not exposed elsewhere to 3 TCE or other irritants and had had no previous respiratory ailments. Shultz testified:

> "I didn't have any reason to think that his symptoms were psychologically mediated in any way or that his description of his symptoms as given to me were for any secondary gain at the time I saw him."

Accordingly, in the absence of any other reasonable explanation, we hold that claimant has carried his burden to establish

that his exposure to 3 TCE on the job was the major contributing cause of the symptoms that required Shultz's medical services. The claim is compensable.

Reversed and remanded with instructions to accept the claim.

IN THE COURT OF APPEALS OF THE STATE OF OREGON

In the Matter of the Compensation of Frank DeCouteau, Claimant.

DeCOUTEAU,
Petitioner,

v.

SAIF CORPORATION et al,
Respondents.

(WCB No. 84-05809; CA A39806)

Judicial Review from Workers' Compensation Board.

Argued and submitted January 16, 1987.

David C. Force, Eugene, argued the cause and filed the brief for petitioner.

Christine Chute, Assistant Attorney General, Salem, argued the cause for respondents. With her on the brief were Dave Frohnmayer, Attorney General, and Virginia Linder, Solicitor General, Salem.

Before Richardson, Presiding Judge, and Newman and Deits, Judges.

NEWMAN, J.

Reversed and remanded to the Board with instructions to hold a hearing on "good cause."

NEWMAN, J.

Claimant seeks review of an order of the Workers' Compensation Board. He had requested a hearing on insurer's denial of his aggravation claim more than 60 days, but less than 180 days, after the denial. The Board affirmed the referee's ruling that claimant did not have "good cause" to file the request after the 60-day period had expired. ORS 656.319[1]. We reverse.

Claimant suffered a compensable low back injury in January, 1981. He moved to North Dakota. In October, 1983, he had low back surgery. His attending physician forwarded the billings and medical records for the surgery to SAIF. On February 8, 1984, SAIF denied claimant's aggravation claim, because

> "it appears that your condition which resulted in surgery in October, 1983, is attributable to a condition which pre-existed your injury of January 8, 1981, as opposed to a direct causal relationship to this injury."

[1] ORS 656.319(1) provides:

"With respect to objection by a claimant to denial of a claim for compensation under ORS 656.262, a hearing thereon shall not be granted and the claim shall not be enforceable unless:

"(a) A request for hearing is filed not later than the 60th day after the claimant was notified of the denial; or

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

On May 21, 1984, claimant filed the request for a hearing.

The referee stated that claimant testified "credibly" that:

> "1. Between receipt of the denial and requesting a hearing, [he] attempted to contact the insurer by the phone at least three times but was unable to get through to anyone in a position of authority. [He] was informed by the insurer that the insurer was not receiving medical reports.
>
> "2. [He] tried to contact his surgeon to make sure the surgeon would send medical reports to the insurer. He called the doctor's office several times but was unable to get through to the doctor. The doctor's office was some 200 miles from [his] home. [He] was without funds and unable to afford a personal visit to the doctor's office.

> "3. [He] was unrepresented by an attorney.
>
> "4. [He] requested a hearing within one week of getting the doctor's report which alleged a causal relationship between his surgery and his previous Oregon industrial injury."

The referee inferred that "claimant did not know he had [a] medical basis for contesting the denial until he finally received his surgeon's report." The referee, however, held that the Board's decision in *William J. Anderson,* 36 Van Natta 1489 (1984), and our decision in *Cogswell v. SAIF,* 74 Or App 234, 702 P2d 81 (1985), are "controlling."[2] Without referring to ORCP 71B(1) or cases decided under *former* ORS 18.160, he concluded that claimant had not established "good cause." The Board affirmed without opinion.

Subsequent to the Board's decision here, we reversed its decision in *William J. Anderson. Anderson v. Publishers Paper Co.,* 78 Or App 513, 717 P2d 635, *rev den* 301 Or 666 (1986). We commented that the Board had ruled that claimant's "subjective belief as to the non-compensability of his claim is not good cause for his failure to file a timely request for hearing." 78 Or App at 516. We then stated:

> "[T]he referee concluded that claimant had established good cause, without referring to ORCP 71B(1) or cases decided under *former* ORS 18.160. In reversing the referee, the Board examined neither the rule nor the cases, as *Brown* requires that it do. Instead, it applied a broadly formulated rule that it had adopted in a prior Board decision.
>
> "Accordingly, we must reverse and remand to the Board for reconsideration under the appropriate law. A decision about 'good cause' is for the Board to make in the first instance. *Brown v. EBI Companies,* [289 Or 455, 616 P2d 457 (1980)]." 78 Or App at 517. (Footnote omitted.)

We reach the same result here.

Reversed and remanded to the Board to hold a hearing on "good cause."

---

[2] Our opinion in *Cogswell* is not controlling here. It is clearly distinguishable on its facts.

IN THE COURT OF APPEALS OF THE
STATE OF OREGON

COOK,
Respondent - Cross-Appellant,
v.
COOS-CURRY ELECTRIC
COOPERATIVE, INC.,
Appellant - Cross-Respondent.
(C85-7-109; CA A39811)

Appeal from Circuit Court, Curry County.

Richard K. Mickelson, Judge Pro Tempore.

Argued and submitted May 29, 1987.

Earl R. Woods, Jr., Coquille, argued the cause for appellant - cross-respondent. With him on the briefs was Engelgau & Woods, Coquille.

James C. Coffey, North Bend, argued the cause for respondent - cross-appellant. With him on the briefs was Hayner, Stebbins & Coffey, North Bend.

Before Buttler, Presiding Judge, and Warren and Rossman, Judges.

WARREN, J.

Affirmed on appeal and on cross-appeal.

WARREN, J.

This is an action brought under ORS 659.121(1) alleging that defendant violated ORS 659.415 when it refused to reinstate plaintiff to his former job as line foreman after his recovery from a compensable injury. The trial court found that plaintiff was capable of performing line foreman work as of November 1, 1984, and that defendant had violated ORS 659.415. It awarded plaintiff back wages, attorney fees and costs.

Defendant appeals, assigning as error the trial court's determination that plaintiff was capable of performing his duties as of November 1, 1984. Plaintiff cross-appeals the trial court's award of attorney fees, claiming that it was error to restrict the award to the amount agreed upon in the contingent fee agreement between plaintiff and his attorney. We affirm on appeal and on cross-appeal.

Plaintiff was employed by defendant as a lineman and was promoted to line foreman in November, 1981. From December, 1977 to June, 1984, he suffered repeated job related injuries to his lower back. He sought treatment for his lower back condition from Dr. Boye in June, 1984. In July, 1984, Boye referred him to Dr. Meyers, an orthopedic surgeon, who recommended a CAT scan of his back. The scan showed nothing abnormal. Meyers' diagnosis was that plaintiff had a recurrent chronic strain in the lumbosacral region. Boye subsequently released plaintiff to return to his regular duties.

However, from July 27 until September, 1984, defendant employed plaintiff in other than line foreman duties, but continued to pay him line foreman pay. In September, 1984, defendant requested opinions of Meyers and Boye as to plaintiff's capability to perform the line foreman job. Meyers replied that there was a high probability of further injury if he returned to his regular work, and Boye responded that it would be beneficial to plaintiff if he were placed in a position that did not require extensive lifting and bending. Defendant notified plaintiff that, based upon the recommendation of Boye, plaintiff was reclassified and demoted to the position of meter reader as of October 1, 1984. Plaintiff accepted that under protest.

In order to resolve the grievance, the parties agreed that plaintiff would see an impartial orthopedic doctor for

evaluation and that his opinion would be binding. Plaintiff was examined by Dr. Whitney, who was of the opinion that plaintiff could return to his former position after completing "back school" and physical therapy. Plaintiff completed both by the end of October, 1984, and was released to work by Whitney. Defendant, however, disregarded Whitney's release and refused to reinstate plaintiff to a line foreman position, because it believed that Whitney was not impartial because plaintiff had previously seen him. Defendant continued to rely on Boye's opinion.

In February, 1985, as a result of an arbitration hearing, plaintiff was required to see another orthopedist, Dr. Hopkins, who said that plaintiff could return to his original occupation without difficulty. Defendant finally reinstated plaintiff to his job as a line foreman in May, 1985.

We review *de novo*. *Wincer v. Ind. Paper Stock Co.*, 48 Or App 859, 864, 618 P2d 15 (1980). The trial court concluded that defendant had no basis to believe that plaintiff was incapable of working as a line foreman after he had completed the back school and the physical therapy recommended by Dr. Whitney. We agree with the trial court's assessment of the evidence.

Defendant relied on the earlier opinions of Boye and Meyers, which were unfavorable to plaintiff, despite Whitney's later examination and release of plaintiff, primarily because Whitney had seen plaintiff before. There was no evidence that Whitney's previous examination affected his conclusion that plaintiff was capable of returning to work. We find that plaintiff established that he was able to return to his former job as of November 1, 1984.

We now turn to the attorney fees award. ORS 659.121(1) provides that the court may allow the prevailing party in an action arising from unlawful employment practices reasonable attorney fees. The trial judge set the attorney fees in an amount equal to one-third of the award. He considered the contingency fee arrangement between plaintiff and his attorney, as well as the complexity of the issues presented, and concluded that one-third was reasonable. We are satisfied that the trial judge did not limit the attorney fees on the basis of the contingency fee agreement, but determined independently that the amount assessed was reasonable.

Affirmed on appeal and on cross-appeal.

IN THE COURT OF APPEALS OF THE STATE OF OREGON

In the Matter of the Compensation of David F. Barrett, Claimant.

BARRETT,
Petitioner,

v.

D & H DRYWALL et al,
Respondents.

(WCB No. 81-02757; CA A41385)

Judicial Review from Workers' Compensation Board.

Argued and submitted April 3, 1987.

James L. Edmunson, Eugene, argued the cause for petitioner. With him on the brief was Malagon & Moore, Eugene.

Kenneth L. Kleinsmith, Portland, argued the cause for respondents. With him on the brief was Meyers & Terrall, Portland.

Before Buttler, Presiding Judge, and Warren and Rossman, Judges.

ROSSMAN, J.

Affirmed.

ROSSMAN, J.

Claimant seeks review of an order of the Workers' Compensation Board on remand from the Supreme Court. This is round two concerning the extent of claimant's permanent disability from a compensable back injury. At the end of the first round, the Supreme Court remanded the case to the Board to determine whether claimant's injury had caused his preexisting noncompensable osteoarthritis to become symptomatic and instructed the Board to consider any permanently disabling symptoms due to the injury's effect on the disease in awarding permanent partial disability. *Barrett v. D & H Drywall,* 300 Or 325, 709 P2d 1083, *on reconsideration* 300 Or 553, 715 P2d 90 (1985). Coupled with that requirement is our determination, not changed by the Supreme Court, that claimant's injury did not cause the underlying degenerative condition to become worse and, therefore, compensable in itself as an occupational disease. *Barrett v. D & H Drywall,* 70 Or App 123, 688 P2d 130 (1984).

Claimant asserts that the Board applied an incorrect test of causation and that the case should again be remanded to the Board for reconsideration. We agree that the Board, in its original order on remand, used some language which suggested that it might have applied an improper test; however, we are satisfied, on *de novo* review, that the Board reached the correct result.

Claimant experienced a compensable back injury in 1980, superimposed on osteoarthritis. We declined to consider

the symptoms of claimant's osteoarthritis in determining the extent of permanent partial disability due to the industrial injury. 70 Or App 123, 688 P2d 130 (1984), *on reconsideration* 73 Or App 184, 698 P2d 498 (1985). The Supreme Court reversed and on its reconsideration stated:

> "If, therefore, the accident described * * * caused that disease to produce symptoms where none existed immediately prior to the accident, and those symptoms produced a loss of earning capacity, then that loss of earning capacity is 'due to' the compensable injury and the statute [ORS 656.214(5)] requires an award of compensation therefor." 300 Or at 555.

In its first opinion on remand, the Board explained what it understood to be the Supreme Court's instruction:

> "We read this statement as consistent with prior law that disabling pain caused by an industrial injury is a part of the calculus in rating extent of permanent disability. [Citation omitted.]
>
> "The issue in this case revolved around the source, not the existence, of the disabling pain, and further involved the question whether claimant had an occupational disease, which the court concluded he did not. We review the court's mandate as directing us to determine whether claimant had disabling pain which is 'due to' the industrial injury and is permanent * * *."

We agree with the Board's understanding of the court's opinion up to that point. The Board then went on to state that, before the symptoms of a preexisting condition can be considered in determining extent of disability, it must be shown that "[the symptoms] would not exist *but for* the industrial injury." (Emphasis supplied.) Claimant asserts that the Board's statement indicates that it followed a "but for" test of causation which caused it erroneously to overlook certain symptoms of osteoarthritis which were brought on by the injury but which would have appeared eventually without the injury. We agree that a "but for" test is not appropriate and that it is not the test suggested by the Supreme Court. However, the remainder of the Board's original order on remand and its order on reconsideration satisfy us that, despite the unfortunate reference to a "but for" test, the Board analyzed the case in accordance with the Supreme Court's instructions. Additionally, on *de novo* review, we find, considering all of claimant's symptoms, that he has been adequately compensated for his disability.

There is considerable evidence that claimant suffers from pain attributable to osteoarthritis. As the Board noted in its first opinion and in its opinion on reconsidation, the medical evidence does not show whether or how much of that pain was brought on by the injury and how much is attributable solely to the natural progression of the disease. Claimant bears the burden of proving by a preponderance of the evidence that the osteoarthritic symptoms which he is experiencing were brought on by the compensable injury. His testimony concerning the onset of the symptoms is not convincing proof, in a case of this complexity, of a relationship. *See Jacobson v. SAIF*, 36 Or App 789, 589 P2d 1146 (1978). We agree with the Board that the evidence justifies an award no greater than 35 percent.

We also conclude that the Board could properly consider the case on remand from the Supreme Court on the record created before the referee and did not have to remand the case to the referee for consideration in the first instance.

Affirmed.

IN THE COURT OF APPEALS OF THE STATE OF OREGON

NICHOLSON,
Appellant,
v.
BLACHLY et al,
Respondents.
(A8511-07449; CA A40516)

Appeal from Circuit Court, Multnomah County.

Charles S. Crookham, Judge.

Argued and submitted April 27, 1987.

Peter O. Hansen, Portland, argued the cause for appellant. On the brief was Warren A. Covington, Portland.

Mildred Carmack, Portland, argued the cause for respondents B. J. Blachly and International Rehabilitation Associates, Inc. On the brief were Allan M. Muir, Portland, Wayne A. Williamson, Portland, Dennis S. Reese, Portland and Schwabe, Williamson, Wyatt, Moore & Roberts, Portland.

Thomas W. Sondag, Portland, argued the cause for respondent Pacific Fruit Express Company. With him on the brief was Spears, Lubersky, Campbell, Bledsoe, Anderson & Young, Portland.

Before Warden, Presiding Judge, and Joseph, Chief Judge, and Van Hoomissen, Judge.

JOSEPH, C. J.

Affirmed.

Van Hoomissen, J., concurring in part; dissenting in part.

JOSEPH, C. J.

Plaintiff appeals from judgments dismissing his complaint for breach of contract and negligence. ORCP 21A. The trial court based the dismissals on the ground that plaintiff's exclusive remedy is under the Workers' Compensation Act. We affirm.

In reviewing an ORCP 21A dismissal, we assume the truth of plaintiff's allegations. *Crosby v. SAIF,* 73 Or App 372, 376, 699 P2d 198 (1985). He was employed by Pacific Fruit Express (PFE), a self-insured employer, earning $11 an hour. In August, 1981, he was injured on the job. PFE undertook to

provide him with vocational rehabilitation services as part of his workers' compensation benefits. In November, 1983, it contracted with International Rehabilitation Associates (IRA), of which Blachly is an employe. The contract provided that IRA would give plaintiff on the job training and that PFE would subsidize his wages during the training period. The base wage provided for in the agreement was $7 an hour. The parties orally agreed that plaintiff would receive a wage subsidy of $4 an hour.

Plaintiff alleges that PFE breached its contract by failing to subsidize his wages so that he would receive $11 an hour. He also alleged that PFE was negligent in acquiring or advising him about the rehabilitation services to be provided by Blachly and IRA. Against Blachly and IRA, he alleges breaches of contract by failing to obtain employment for him at $11 an hour and by negligently providing rehabilitation services.

We turn first to plaintiff's contention that the trial court erred in dismissing his claims against PFE. He argues that his contract claim against PFE is for breach of an oral contract made *after* he was injured, that PFE's liability for that breach and for negligence is separate from its liability arising from his compensable injury and that the court erred in ruling that his exclusive remedy is in the workers' compensation system. PFE argues that, as to employers and employers' insurers, ORS 656.018 substitutes exclusive workers' compensation liability for "all other liability arising out of compensable injuries." It characterizes plaintiff's breach of contract and negligence claims as parts of a dispute over the *amount* of compensation to which he is entitled. As such, the

claims arise from a compensable injury and are within the exclusive ambit of the workers' compensation system. PFE argues further that the workers' compensation statutes provide that the forum for all disputes concerning a claim, including everything concerning an employer's responsibility for vocational rehabilitation, is the workers' compensation system.

Jurisdiction for "matters concerning a claim under ORS 656.001 to 656.794" is under the workers' compensation system. ORS 656.708(3). Matters concerning a claim "are those matters in which a worker's right to receive compensation, or the amount thereof, are directly in issue." ORS 656.704(3); *see also Hayden v. Workers' Compensation Dept.*, 77 Or App 328, 331, 713 P2d 612 (1986). Compensation includes vocational rehabilitation assistance. ORS 656.005(9); ORS 656.340(3).[1] At the time of plaintiff's injury, ORS 656.340[2] provided, in relevant part:

"(2) * * * If the worker is not able to return to the previous employment, the insurer or self-insured employer shall assist the worker in obtaining similar or suitable employment.

"(3) *Assistance under this section shall include,* but not be limited to use of the insurer's or self-insured employer's placement and rehabilitation resources, job search, on-the-job placement and *contracting with the Vocational Rehabilitation Division of the Department of Human Resources or with*

suitable private rehabilitation services for the purpose of reemploying the worker at a position or a wage as close as possible to the worker's occupation or employment at the time of injury. All vocational assistance services provided to injured workers shall be in accordance with rules prescribed by the director." (Emphasis supplied.)

Although plaintiff contends that PFE breached (and negligently performed) an obligation undertaken *after* he was injured by means of a statutorily authorized contract to provide benefits, the essential wrong alleged is the failure of PFE to provide adequate compensation, and that is subject to the Workers' Compensation Act exclusively. Therefore, the trial court did not err in dismissing plaintiff's complaint against PFE.

Plaintiff also contends that the trial court erred in dismissing his claims against Blachly and IRA. He argues that the exclusivity of workers' compensation remedies does not extend to them and that his claims are not barred by the Workers' Compensation Act. Blachly and IRA argue that vocational rehabilitation assistance is one of the benefits provided to injured workers under the act in lieu of any other remedies that they otherwise might have had. They rely on *SAIF v. Harris*, 66 Or App 165, 168, 672 P2d 1384 (1983). They are correct. ORS 656.018 states, in relevant part:

---

[1] The duty to provide vocational rehabilitation stated in the current statute, *see* n 2, *infra*, is in all essentials the same as at the time of claimant's injury.

[2] ORS 656.340 was amended by Or Laws 1985, ch 600, § 11, effective January 1, 1986, to provide, in relevant part:

"(3) After the attending physician has released a worker to return to work, the insurer or self-insured employer shall inform the worker about reemployment rights and the responsibility of the insurer to request reinstatement, and shall request reinstatement on behalf of the worker, to the worker's former position of employment or to any other employment with the employer who employed the worker at the time of injury which is available and suitable if the former position is not available. Such a request shall be considered a demand for reinstatement of reemployment by the worker for the purposes of ORS 659.415 and 659.420.

"(4) As soon as possible, and not more than 30 days after the contact required by subsection (1) of this section, the insurer or self-insured employer shall cause an individual certified by the director to provide vocational assistance to determine whether the worker is eligible for vocational assistance. If the worker is eligible, the insurer or self-insured employer shall begin vocational assistance or refer the worker for vocational assistance to the authorized vocational assistance provider.

"(5) A worker may object to the insurer's or self-insured employer's selection of a vocational assistance provider one time. If not otherwise agreed to by the insurer or self-insured employer and the worker, any further selection of a vocational assistance provider shall be resolved pursuant to ORS 656.283(2) and the rules adopted by the director.

"(6) The objectives of vocational assistance are to return the worker to employment which is as close as possible to the worker's regular employment at a wage as close as possible to the worker's wage at the time of injury. The primary condition of eligibility for vocational assistance shall be that, because of the injury, the worker needs assistance to return to the previous employment or to any employment, or the worker with assistance can return earlier to the previous employment. Vocational evaluation, help in directly obtaining employment and training shall be available under conditions prescribed by the director. The director may establish other conditions for providing vocational assistance, including those relating to the worker's availability for assistance, participation in previous assistance programs connected with the same claim and the nature and extent of assistance that may be provided. Such conditions shall give preference to direct employment assistance over training and to a return to employment with the previous employer over employment with a new employer.

"(7) An insurer or self-insured employer may utilize its own staff or may engage any other vocational assistance provider to provide vocational assistance to an injured worker. All personnel and vocational assistance providers must meet the requirements of this section and the rules adopted pursuant thereto."

"(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 * * *."

"* * * * *

"(2) *The rights given to a subject worker* and the beneficiaries of the subject worker 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 * * *." (Emphasis supplied.)

Although Blachly and IRA are not plaintiff's "employer," they are within the scope of the protection of 656.018 in providing a service the right to which exists only by reason of and pursuant to the Act.

At the time of his injury, OAR 436-61-191[3] provided that, in addition to requesting a hearing on a vocational rehabilitation assistance question under ORS 656.283(1), a claimant could request the Rehabilitation Review Division to resolve a dispute with a vocational assistance provider:

"(1) The purpose of this rule is to provide, as an alternative to a hearing under ORS 656.283, a method of resolving a vocational assistance question. * * *

"(2) A worker who is dissatisfied with a decision of the insurer regarding eligibility for vocational assistance, *or regarding the nature or quality of the assistance being received or offered,* should first attempt to resolve the matter with the insurer.

"(3) A worker with unresolved dissatisfaction * * * may request the Rehabilitation Review Division to resolve the matter. * * *

"(4) If the * * * Division is not otherwise able to resolve the matter * * * it may convene a conference of the parties. Attendance by * * * any vocational rehabilitation organization who is a party may be required by the Division. * * *

"(5) * * * Appeal of the order may be made as provided in ORS 656.283.

"(6) At any time * * * if * * * an order is necessary for a worker to receive vocational assistance conforming to ORS Chapter 656 and these rules, the Director or the division may

order the insurer to provide timely and appropriate vocational assistance * * *. Appeal of the order may be made as provided in ORS Chapter 656." (Emphasis supplied.)

As we have pointed out in sustaining the dismissal of the claim against PFE, the Workers' Compensation Department has jurisdiction over all matters concerning claims. There is nothing in the statutory framework, as it existed in 1981 or as it exists now, to support claimant's position that a contract provider of vocational rehabilitation services should be regarded as outside the system of which it is by statute made an integral part and which creates and sustains the right to the services.

The contention that ORS 656.018 limits the liability only of employers and insurers misses the point. The express general legislative intent is that the Workers' Compensation

[3] The rule has been renumbered OAR 436-120-210 and has been amended.

Act constitutes a complete and exclusive statement of the rights and remedies of injured workers. *Haret v. SAIF*, 72 Or App 668, 697 P2d 201 (1985). The only exceptions to that exclusivity are those created expressly by the legislature. *See SAIF v. Harris*, 66 Or App 165, 168, 672 P2d 1384 (1983). The trial court did not err.

Affirmed.

VAN HOOMISSEN, J., concurring in part and dissenting in part.

I agree with the majority that, under ORS 656.018, PFE's liability is to be exclusively determined through the Workers' Compensation Act (Act). However, I dissent from the dismissal of plaintiff's action against Blachly and IRA. I would hold that the exclusivity provided by the statute does not extend to providers of vocational rehabilitation assistance who are not employes of the worker's employer or employer's insurer.

ORS 656.018 provides, in relevant part:

> "(1)(a) The liability of every *employer* who satisfies the duty required by ORS 656.017(1) *is exclusive* * * *."
>
> "* * * * *
>
> "(3) 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 * * *." (Emphasis supplied.)

Vocational rehabilitation providers are not exempted from liability. ORS 656.018(2) also provides: "The rights given to a subject worker [under the Workers' Compensation Act] * * * *are in lieu of any remedies* they [sic] 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 * * *." (Emphasis supplied.) The Act is intended to govern those who stand in the relationship of employer and employe. It limits the liability of employers in exchange for certainty of recovery for injured workers. It does not replace legal remedies which an injured worker may have against persons not enumerated in ORS 656.018 and who do not bear burdens under the Act which are reciprocal for the exclusivity granted by the Act.

In holding that the exclusivity of the Act did not bar a worker's medical malpractice suit against a doctor treating him for injuries compensated under the Act, the Supreme Court explained:

> " 'It would [be] unreasonable to assume that the legislature in its enactment of the [Act] intended to save a class of wrongdoers unrelated to the compensation scheme from liability which the law had theretofore imposed upon them, or that independent professions by the fact of business contact with the employer should be relieved of responsibility for mistake or neglect resulting in secondary affliction.' " *Wimer v. Miller*, 235 Or 25, 31, 383 P2d 1005 (1963), *quoting Fauver v. Bell*, 192 Va 518, 530, 65 SE2d 575 (1951).

Blachly's and IRA's rehabilitation services are provided as part of plaintiff's workers' compensation benefits, as were the medical services in *Wimer*. The Act does not bar a negligence

action against a doctor treating an injured worker, and it should not be construed to bar a negligence action against vocational rehabilitation providers.

Although ORS 656.018 does not bar plaintiff's claim against IRA and Blachly, the question remains whether the Act has abrogated his common law claim by providing a statutory method to resolve the issue within the Workers' Compensation Department. The jurisdiction of the Hearings Division and the Board are established by ORS 656.708(3). That statute provides that the division is the "forum for deciding * * * all cases, disputes and controversies regarding matters concerning a claim under ORS 656.001 to 656.794 * * *."

"Matters concerning a claim" is defined as those "in which a worker's right to receive compensation,[1] or the amount thereof, are directly in issue." ORS 656.704(3). ORS 656.340 provides that compensation includes vocational rehabilitation services.[2] A claimant may request a hearing on any question concerning rehabilitation issues. ORS 656.283(1). At the time of plaintiff's injury, OAR 436-61-191[3] provided an alternative method to a hearing under ORS 656.283 for resolving vocational assistance questions.[4]

ORS 656.283 and OAR 436-61-191 allow plaintiff the opportunity to influence his *ongoing* rehabilitation in a manner similar to the statutes and administrative rules providing resolution of disputes concerning the necessity and appropriateness of medical services. *See* OAR 436-10-001, OAR 436-10-110. As such, disputes under those statutes and rules constitute "matters concerning a claim," and jurisdiction lies in the Hearings Division. *See SAIF v. Belcher*, 71 Or App 502, 505, 692 P2d 711 (1984). However, an action alleging *negligent medical care* goes beyond "matters concerning a claim." Similarly here, the conduct for which plaintiff seeks relief, *negligent provision of rehabilitation services,* goes beyond the scope of "the right to receive compensation or the amount thereof." ORS 656.704(3); *see Crosby v. SAIF*, 73 Or App 372, 375, 699 P2d 198 (1985). The mechanisms provided under ORS 656.283 and OAR 436-61-191 do not extend to an action for contract damages resulting from IRA's and Blachly's alleged failure to obtain appropriate employment or to an action to recover damages for injury caused by alleged negligent provision of rehabilitation services.

[1] There is no dispute concerning plaintiff's right to compensation in the form of vocational rehabilitation services.

[2] At the time of plaintiff's injury, ORS 656.340 provided, in relevant part:

"(2) The insurer or self-insured employer shall assist the worker in returning to the worker's previous employment. If the worker is not able to return to the previous employment, the insurer or self-insured employer shall assist the worker in obtaining similar or suitable employment.

"(3) Assistance under this section shall include, but not be limited to use of the insurer's or self-insured employer's placement and rehabilitation resources, job search, on-the-job placement and contracting with the Vocational Rehabilitation Division of the Department of Human Resources or with suitable private rehabilitation services for the purpose of reemploying the worker at a position or a wage as close as possible to the worker's occupation or employment at the time of injury. All vocational assistance services provided to injured workers shall be in accordance with rules prescribed by the director."

Amendments to ORS 656.340, effective January 1, 1986, are not applicable in this case. *See* Or Laws 1985, ch 600, § 11.

[3] OAR 436-61-191 has been renumbered 436-120-210.

[4] For the text of OAR 436-61-191, see 86 Or App 645 at ____.

Plaintiff alleges a wrong outside the jurisdiction of the Workers' Compensation Department and committed by someone other than his employer or those entitled by statute to share the employer's immunity. Therefore, the jurisdiction of these claims lies not in the Department but in circuit court. I would affirm the dismissal of the action against PFE and reverse the dismissal of the action against Blachly and IRA and remand for trial.

IN THE COURT OF APPEALS OF THE STATE OF OREGON

In the Matter of the Compensation of
Gary E. Tollefson, Claimant.
INTERNATIONAL PAPER COMPANY,
Petitioner,
v.
TOLLEFSON,
Respondent.
(WCB 85-03658; CA A41258)

Judicial Review from Workers' Compensation Board.

Argued and submitted April 10, 1987.

Paul L. Roess, Coos Bay, argued the cause for petitioner. With him on the brief was Foss, Whitty & Roess, Coos Bay.

Jim L. Scavera, Coos Bay, argued the cause and filed the brief for respondent.

Before Warden, Presiding Judge, and Van Hoomissen and Young, Judges.

YOUNG, J.

Affirmed.

YOUNG, J.

Employer seeks review of a Workers' Compensation Board order that affirmed the referee's award of compensation. The issue is whether claimant proved by a preponderance of the evidence that his right elbow condition is a compensable occupational disease. ORS 656.802(1)(a). We affirm.

Claimant worked for employer from February, 1983, to September 24, 1985. Until March, 1984, he worked as a grader trainee on the green chain. In that job he used a picaroon with his right arm to straighten lumber. He testified that, early in 1984, he began to have pain in his right elbow. The pain was usually present at the end of the shift, after work on his way home or sometimes after he got home. Although the pain continued, he did not seek treatment at that time. In March, 1984, claimant was assigned to work on an automated lumber sorter, which did not require the use of the picaroon.

Most of that work was button-pushing, although he did clean up the work area at the end of his shift. His elbow continued to ache periodically. In September, 1984, he told his foreman that he was having trouble straightening lumber because of his elbow and that he intended to see a doctor.[1]

Claimant saw Dr. Crocker, who referred him to Dr. Boughal, an orthopedic surgeon. Both doctors noted that claimant could not fully extend his right arm and that attempts to do so caused severe pain. After unsuccessful attempts at conservative treatment, Boughal diagnosed a probable intra-articular loose body and recommended surgery. On December 21, 1984, surgery revealed no loose body, but it did reveal an enlarged synovial fringe which appeared to mechanically hinder the extension of the elbow. After the fringe was excised, complete extension was possible. However, within ten days after surgery the elbow could not be extended beyond 20 degrees. The pain in his arm also recurred. Claimant was referred to Dr. Butters, who made an objective finding of flexion contracture, with which Boughal agrees. The doctors have been unable to identify the cause of the contracture or pain.

On January 3, 1985, claimant filed a claim, which was denied. The referee awarded compensation. On August 1, 1986, the Board affirmed the referee's order. Employer moved for reconsideration. On August 19, 1986, the Board issued its order on reconsideration, withdrawing the prior order, adhering to it and republishing it. On September 3, 1986, employer filed the petition for review. Claimant contends that, because employer failed to file within 30 days of the August 1 order, we must dismiss. ORS 656.295(8). In its petition, employer seeks review of both orders and both are attached to the petition. The later order expressly withdraws the earlier one. Hence, the proper order for review is the one of August 19. The petition for judicial review was timely filed. We turn to the merits.

In order to establish that the elbow condition is compensable, claimant must prove by a preponderance of the evidence that his work was the major contributing cause of his condition. *Reining v. Georgia-Pacific Corp.*, 67 Or App 124, 128, 676 P2d 926 (1984). The referee concluded that claimant's elbow condition is compensable:

> "Given the nature of claimant's work with the picaroon, his credible testimony as to the occurence of those symptoms, and the lack of any suggested non-work culprit, I conclude that it is more likely than not that claimant's work for International Paper was the major contributing cause of his undiagnosed elbow condition."

The Board affirmed.

Although it is a close case, we also find claimant's elbow condition compensable. Before the surgery, Boughal could not identify the particular etiology of the elbow pain and loss of extension. His post-surgery diagnosis of the extension problem remains an enlarged synovial fringe. The cause or causes of the post-surgery flexion contracture are unknown. The pain persists, and Boughal is unable to identify its cause. Without a specific diagnosis, it is difficult to be certain that

[1] Claimant's supervisor and claimant completed a report used for the purposes of plant safety but did not complete a workers' compensation form.

claimant's work is the major contibuting cause of his disability. However, certainty is not the degree of proof required; preponderance of the evidence is. *Hutchenson v. Weyerhaeuser*, 288 Or 51, 55-56, 602 P2d 268 (1979).

The referee found claimant credible. His testimony was that the elbow pain at first coincided with the use of the jackhammer. Boughal also testified:

> "[Claimant's] symptoms occurred while he was an employee of International Paper. And the type of work that he did required repetitive and forceful use of the elbow. And, indeed, those working activities, when he would engage in them, exacerbated his painful symptoms.
>
> "* * * * *
>
> "On the basis of [claimant's] clinical history, physical findings on examination, radiographic studies and result of surgery it is my opinion that [claimant's] disability related to his right elbow is more likely than not related to his working conditions. It is my opinion that his employment at the International Paper Company is the major contributing cause of [claimant's] disability."

There is no evidence that claimant suffered from elbow and arm problems before his work on the green chain. There is no evidence of any cause outside his employment to rebut Boughal's opinion. *See Gilbert v. SAIF*, 63 Or App 320, 325, 663 P2d 807 (1983). We conclude that claimant has proved by a preponderance of the evidence that his elbow condition is compensable.

Affirmed.

IN THE COURT OF APPEALS OF THE STATE OF OREGON

In the Matter of the Compensation of Everett G. Wells, Claimant.

WELLS,
Petitioner,
v.
PETE WALKER'S AUTO BODY et al,
Respondents.

(WCB 84-12139; CA A38440)

Judicial Review from Workers' Compensation Board.

Argued and submitted December 5, 1986.

James L. Edmunson, Eugene, argued the cause for petitioner. With him on the brief was Malagon & Moore, Eugene.

Christine Chute, Assistant Attorney General, Salem, argued the cause for respondent SAIF Corporation. With her on the brief were Dave Frohnmayer, Attorney General, James E. Mountain, Jr., Solicitor General, and Jeff Ellis, Certified Law Student, Salem.

Before Richardson, Presiding Judge, and Newman and Deits, Judges.

DEITS, J.

Affirmed.

DEITS, J.

In 1983, claimant suffered a herniated disc, which SAIF accepted as a disabling injury. In May, 1984, he was released to return to light work. He was unable to find work and, in July, 1984, applied for unemployment benefits. From August 1, 1984, until October 19, 1984, he received $61 per week. SAIF offset the unemployment benefits against his temporary disability benefits. He requested a hearing, claiming that unemployment benefits should not have been offset. The Workers' Compensation Board affirmed the referee's determination that the offset was proper. We affirm.

In *Edwards v. Employment Division,* 63 Or App 521, 664 P2d 1151 (1983), we considered whether a worker who was receiving worker's compensation benefits could also be eligible for unemployment compensation:

> "In the context of the workers' compensation law, a worker receiving temporary total disability may be estopped from simultaneously claiming unemployment benefits, because *it is implicit in a total disability award that a worker is unable to work.* ORS 656.210. On the other hand, a worker receiving temporary partial disability under ORS 656.212, or permament partial disability under ORS 656.214 may be 'able to work.' " 63 Or App at 525. (Emphasis supplied.)

To obtain unemployment compensation, a claimant must establish that he is *able,* available, actively seeking and unable to obtain employment. ORS 657.155(1)(c). Claimant's receipt of unemployment benefits *prima facie* demonstrates that he is able to work within the meaning of the Unemployment Compensation Law. That would appear to conflict with his eligibility to receive temporary total disability benefits.

Claimant argues, however, that to offset temporary total disability benefits by the amount of unemployment benefits received or to convert temporary total disability to temporary partial disability defeats the purpose of Workers' Compensation law to encourage a speedy return to work. We do not agree. ORS 656.012(2)(a) provides that the objectives are

> "[t]o provide, regardless of fault, sure, prompt and complete medical treatment for injured workers and *fair, adequate and reasonable income benefits* to injured workers and their dependents[.]" (Emphasis supplied.)

The legislature has provided formulas for temporary total and temporary partial disability benefits which give effect to that policy. ORS 656.210(1);[1] ORS 656.212. The allowance of an offset against temporary total disability for unemployment benefits is consistent with the policy.

By representing that he is able to work by seeking unemployment benefits, claimant has demonstrated that his disability is no longer total.[2] ORS 656.212 provides:

> "When the disability is or becomes partial only and is temporary in character, the worker shall receive for a period not exceeding two years that proportion of the payments provided for temporary total disability which his loss of earning power at any kind of work bears to his earning power existing at the time of the occurrence of the injury."

OAR 436-60-030 establishes procedures when post-injury wages are received. It provides, in part:

"(1) The rate of temporary partial disability compensation due a worker shall be determined by:

"(a) Subtracting the post-injury wage earnings available from any kind of work; from

"(b) The wage earnings from the employment at the time of, and giving rise to, the injury; then

"(c) Dividing the difference by the wage earnings in (b) to arrive at the percentage of loss of earning power; then

"(d) Multiplying the current temporary total disability compensation rate by the percentage of loss of earning power."

The Board has construed "wage earnings" as used in

the rules to include unemployment benefits.[3] That interpretation is consistent with applicable law and the legislative policy. When a worker is receiving unemployment benefits by representing an ability to work, those benefits may be treated as receipt of post-injury wages.

Affirmed.

---

[1] ORS 656.210(1) provides:

"When the total disability is only temporary, the worker shall receive during the period of that total disability compensation equal to 66-2/3 percent of wages, but not more than 100 percent of the average weekly wage nor less than the amount of 90 percent of wages a week or the amount of $50 a week, whichever amount is lesser. Notwithstanding the limitation imposed by this subsection, an injured worker who is not otherwise eligible to receive an increase in benefits for the fiscal year in which compensation is paid shall have the benefits increased each fiscal year by the percentage which the applicable average weekly wage has increased since the previous fiscal year."

[2] Temporary total disability benefits may be continued as temporary partial disability benefits if a worker finds employment, OAR 436-60-030(3), or refuses employment. OAR 436-60-030(5).

[3] The Board's treatment of private insurance benefits is not before us, and we make no comment about whether those benefits should be treated differently from statutory unemployment benefits.

IN THE COURT OF APPEALS OF THE
STATE OF OREGON

In the Matter of the Compensation of
Leon E. Cowart, Claimant.

COWART,
Petitioner,

v.

SAIF CORPORATION et al,
Respondents.

(WCB 84-02070; CA A41079)

Judicial Review from Workers' Compensation Board.

Argued and submitted March 2, 1987.

Willard E. Merkel, Portland, argued the cause for petitioner. With him on the brief was Galton, Popick & Scott, 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.

DEITS, J.

Reversed and remanded.

DEITS, J.

Claimant seeks reversal of a Worker's Compensation Board order holding that his request for a hearing was untimely. We reverse and remand.

Claimant was injured in June, 1981, while driving a truck for employer. The 801 form was completed by employer, because claimant was unable to do so, due to his injury. On the form, it was stated that the injury was to the shoulder and neck. Employer accepted the claim one week after the accident, and SAIF paid for all treatment, including treatment for low back complaints.

On December 13, 1983, SAIF issued a partial denial, denying responsibility for treatment of claimant's low back condition. The reasons given were that the back condition pre-existed the 1981 accident and that it was not caused or worsened by that accident. SAIF sent the denial by certified mail on December 13. It sent copies of the denial to six doctors and hospitals, the Compliance Division and employer. It did not send a copy to claimant's attorney, even though SAIF knew that claimant was represented and the attorney had asked SAIF to send all discovery documentation about the claim directly to him. Claimant received the denial letter on January 9, 1984, but did not notify his attorney, with whom he had left instructions to appeal all denials. The attorney learned of the denial on February 24, 1984, 73 days after it was issued, and filed a request for hearing on that day.

The Board correctly held that the request for hearing was untimely. A request must be filed within 60 days after the claimant is notified, unless good cause for failure to file within that time is shown. ORS 656.319(1). The date of mailing, not receipt, starts the running of the 60 days. *Madewell v. Salvation Army*, 49 Or App 713, 716, 620 P2d 953 (1980). Although claimant did not receive the notice until January 9, 1984,[1] he received it well before the expiration of 60 days. He could have filed a timely request with reasonable diligence.

The Board also held that claimant did not show "good cause" under ORS 656.319(1)(b) for his failure to file a

timely request for a hearing. However, in making its determination, the Board did not refer to ORCP 71(B)(1) or cases decided under *former* ORS 18.160. The Board is required to make the decision concerning "good cause" on the basis of the considerations in those sources. We reverse and remand for reconsideration. *See DeCouteau v. SAIF*, 86 Or App 502, ___ P2d ___ (1987).

Reversed and remanded.

[1] For some unknown reason, the Postal Service was unable to deliver the letter to claimant before that date.

IN THE COURT OF APPEALS OF THE STATE OF OREGON

In the Matter of the Compensation of Charlotte J. Johnson, Claimant.

JOHNSON,
Petitioner,

v.

SPECTRA PHYSICS et al,
Respondents.

(83-02119, 83-02685, 83-10719; CA A33862)

On remand from the Oregon Supreme Court, *Johnson v. Spectra Physics*, 303 Or 49, 733 P2d 1367 (1987).

Judicial Review from Workers' Compensation Board.

Submitted on remand May 6, 1987.

David C. Force, Eugene, argued the cause and filed the brief for petitioner.

Bruce L. Byerly, Portland, argued the cause and filed the brief for respondents Spectra Physics and Western Employers Insurance.

Jerald P. Keene, Portland, argued the cause for respondents EBI Companies and Junction City Center. On the brief were Craig A. Staples and Roberts, Reinisch & Klor, P.C., Portland.

David Runner, Assistant Attorney General, Salem, argued the cause for respondents SAIF Corporation and Marloc Corporation. With him on the brief were Dave Frohnmayer, Attorney General, and James E. Mountain, Jr., Solicitor General, Salem.

Before Warden, Presiding Judge, and Joseph, Chief Judge, and Young, Judge.

JOSEPH, C. J.

Remanded to Workers' Compensation Board for proceedings not inconsistent with this opinion.

JOSEPH, C. J.

This case is before us on remand from the Supreme Court. 303 Or 49, 733 P2d 1367 (1987). That court instructed us to determine, first, whether claimant's carpal tunnel syndrome (CTS) is compensable by Junction City Center (Junction), her second employer. In our original disposition of this case, we determined, and the Supreme Court affirmed, that the CTS is compensable by Marloc, the first employer. We would have assigned sole responsibility to Marloc at that time but for the technicality of what we thought to be an improper "backup denial" on the part of Junction. We remanded the case at that time with the understanding that the Board would apply *Retchless v. Laurelhurst Thriftway,* 72 Or App 729, 696 P2d 1181, *rev den* 299 Or 251 (1985), which holds that an accepting employer is responsible for compensation until someone else is determined to be responsible.

As we stated in our original opinion, 77 Or App 1, 712 P2d 125 (1985), both doctors who treated claimant agree that her work activity at Marloc was the major contributing cause of her carpal tunnel syndrome. The evidence establishes that the employment at Marloc was the actual cause of the CTS. On remand, claimant argues that we should apply the last injurious exposure rule and hold Junction responsible. The rule is not applicable here, because sufficient proof of actual causation in the earlier employment exists. *Runft v. SAIF,* 303 Or 493, 502, 733 P2d 1367 (1987). Because the employment at Marloc was the actual cause of claimant's occupational disease, Marloc is the responsible employer.

The Supreme Court's remand also instructs us to determine penalties, if any, against EBI for failing to respond to claimant's claim within 60 days.[1] ORS 656.262(10) provides that "if the insurer * * * unreasonably delays acceptance or denial of the claim, the insurer * * * 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." The issue of unreasonable delay has never been dealt with by a referee or the Board; therefore, we remand that issue to the Board.

Remanded to Workers' Compensation Board for proceedings not inconsistent with this opinion.

[1] Although it used the term "claim," the Supreme Court really meant "portion of a claim," referring to the notice of the CTS which claimant gave after filing her original claim. *See Johnson v. Spectra Physics,* 303 Or 49, 56, 733 P2d 1367 (1987).

IN THE COURT OF APPEALS OF THE
STATE OF OREGON

In the Matter of the Compensation of
Emma J. Fenton, Claimant.

FENTON,
Petitioner,

v.

SAIF CORPORATION et al,
Respondents.

(WCB 84-02176; CA A40730)

Judicial Review from Workers' Compensation Board.

Argued and submitted June 1, 1987.

Robert K. Udziela, Portland, argued the cause for petitioner. With him on the brief was Pozzi, Wilson, Atchison, O'Leary & Conboy.

Darrell E. Bewley, Assistant Attorney General, Salem, argued the cause for respondents. With him on the brief were Dave Frohnmayer, Attorney General, and Virginia L. Linder, Solicitor General, Salem.

Before Warden, Presiding Judge, and Van Hoomissen and Rossman, Judges.

VAN HOOMISSEN, J.

Reversed and remanded.

Warden, P. J., dissenting.

VAN HOOMISSEN, J.

Claimant seeks review of a Workers' Compensation Board order which affirmed the referee's decision that claimant's cervical injury was not compensable. On *de novo* review, ORS 656.298, we reverse.

On February 2, 1982, claimant sustained a compensable injury to her back. She worked until February 8, when she took time off because of severe pain. She returned to work on March 1 and suffered an increase in symptoms by April 7. Her condition required further medical treatment and time loss. She was treated by Dr. Rabin and Dr. Bert. On May 3, while on her way to see Rabin for treatment of her back, claimant suffered a neck injury in an automobile accident, when her car, which was stopped at a gas station, and it was struck by another car. Rabin treated her neck injury and notified SAIF that medical and time loss benefits would be paid by the automobile liability insurer.

A settlement with the liability insurer was proposed, and claimant's attorney wrote SAIF inquiring what part of that settlement SAIF would claim. SAIF responded that it considered claimant's neck injury to be separate from her back injury and that, because the automobile liability carriers had paid the medical and time loss due to the neck injury, "SAIF does not have an interest in any settlement which you may

make in behalf of claimant Fenton with the insurance carrier for the accident[.]"

On July 29, claimant had back surgery. She continued to be treated by Rabin and Bert for her back injury, with occasional mention of her neck injury. In September, 1983, a determination order awarded her time loss and 20 percent permanent partial disability for her back injury. She requested a hearing, contending that her neck condition is a compensable consequence of her back injury.

A hearing was held in October, 1983. When SAIF expressed surprise about the neck claim, the referee granted a continuance. SAIF thereafter issued a denial of the neck claim, stating that there was no medical connection between the neck injury and the compensable back injury. The referee concluded, *inter alia,* that "the neck injury or cervical injury sustained by claimant as a result of the automobile accident is

too remote from claimant's employment and from the expected consequences of her work injury" to be compensable. The Board agreed.

Claimant argues that, because she was on her way to see Rabin for treatment of her compensable back injury when her neck was injured, the neck injury arose out of an activity that was a "direct and natural consequence" of the treatment for the original compensable injury and, therefore, it is compensable. She relies by analogy on *Williams v. Gates, McDonald & Co.*, 300 Or 278, 709 P2d 712 (1985); *Firkus v. Alder Cr. Lbr.*, 48 Or App 251, 617 P2d 620 (1980), *rev den* 290 Or 302 (1981); and *Wood v. SAIF*, 30 Or App 1103, 569 P2d 648 (1977), *rev den* 282 Or 189 (1978). SAIF argues that the injury was too remote from claimant's employment to be compensable, that it was caused by the negligence of a third party not related to the employer and that claimant faced a risk faced by any person who drives on the public streets.[1] SAIF also argues that the facts show a situation similar to that of a worker who is injured while commuting to work:

> "While it is necessary for the worker to travel to work, and it is to the benefit of the employer for the employe to get to work, the act is too remote to be covered by the workers' compensation law."

ORS 656.005(8)(a) defines a compensable injury as "an accidental injury * * * arising out of and in the course of employment requiring medical services or resulting in disability or death[.]" Oregon has not previously addressed whether an injury sustained in an accident while enroute to a physician for treatment of a compensable injury arises out of and in the course of employment. We have held that an injury incurred while engaged in a vocational rehabilitation program is a compensable consequence of the original injury. *See Firkus v. Alder Cr. Lbr., supra; Wood v. SAIF, supra.* It has also been recognized that an injury incurred as a result of medical treatment for a compensable injury is a compensable consequence of the industrial injury. *See Williams v. Gates, McDonald & Co., supra; Wood v. SAIF, supra.*

[1] SAIF's argument that claimant will be compensated twice ignores the fact that claimant's attorney notified SAIF that a settlement had been negotiated with Allstate and offered SAIF an opportunity to assert its claim to the proceeds of that settlement. SAIF declined to make any claim.

Larson has recognized that some injuries not directly within the scope of employment should be compensable.

> "Since, in the strict sense, none of the consequential injuries we are concerned with are in the course of employment, it becomes necessary to contrive a new concept, which we may for convenience call 'quasi-course of employment.' By this expression is meant activities undertaken by the employee following upon his injury which, although they take place outside the time and space limits of the employment, and would not be considered employment activities for usual purposes, are nevertheless related to the employment in the sense that they are necessary or reasonable activities that would not have been undertaken but for the compensable injury. 'Reasonable' at this point relates not to the method used, but to the category of activity itself. * * * Quasi-course activities in this sense would include, for example, making a trip to the doctor's office * * *[.]" 1 Larson *Workmen's Compensation Law*, § 13.11(d), 3-379 (1985). (Footnotes omitted.)

Larson focuses specifically on travel to a physician for treatment of a compensable injury.

> "When an employee suffers additional injuries because of an accident in the course of a journey to a doctor's office occasioned by a compensable injury, the additional injuries are generally held compensable, although there is some *contra* authority. If the journey takes place immediately after the first injury occurs, the chain of causation is most readily visible, as when an employee was being rushed to a hospital following a compensable injury and sustained further injury when the ambulance was involved in a collision. But, quite apart from the element of immediacy, a fall or automobile accident during a trip to a doctor's office has usually been considered sufficiently causally related to the employment by the mere fact that a work-connected injury was the cause of the journey, without any necessity for showing that the first injury in some way contributed to the fall or the accident. * * *
>
> "When compensation has been denied in this type of case, there has usually been some added factor weakening the causal connection, such as doubt about whether the trip was really authorized, or termination of the employment relation before the second injury occurred. * * *
>
> "In the simple case, however, of a trip to the doctor's office necessitated by a compensable injury, the arguments put forward by the Kansas court in [*Taylor v. Centex Construction Co.*, 191 Kan 130, 379 P2d 217 (1963)] are difficult to answer.

> The court noted that the employer is under a statutory duty to furnish medical care, and that the employee is similarly under a duty to submit to reasonable medical treatment under the act. The provisions of the act, in turn, become by implication part of the employment contract. This being so, the better view appears to be that accidental injuries during a trip made pursuant to this statutory and contractual obligation are work connected." 1 Larson *Workmen's Compensation Law*, § 13.13, 3-398 (1985). (Italics in original; footnotes omitted.)

As we stated in *Wood v. SAIF, supra:*

> "The principle we glean from *Larson* is that the Workers' Compensation Act concept of compensability for injuries sustained in the course of and arising out of employment includes injuries during activities which are a direct and natural consequence of the original injury." 30 Or App at 1108.

We conclude that, when a worker is injured in an accident which occurs during a trip to see a physician for treatment of a compensable injury, the new injury also is compensable.[2] Claimant's trip to Rabin's office was a direct and natural consequence of her compensable injury. Therefore, her neck injury is compensable.

Reversed and remanded.

WARDEN, P. J., dissenting.

Because I disagree with the conclusion of the majority that claimant was en route to the office of her treating chiropractor when she sustained a cervical injury in a collision, I respectfully dissent.

Claimant sustained her injury in May, 1982, when she made a side trip off the public way to Dr. Rabin's office and into a service station, to obtain gasoline for her vehicle. While she was parked in the station another vehicle backed into hers, causing the injury. Assuming that claimant's trip to Rabin's office for chiropractic treatment of her compensable low back injury was equivalent to a trip made for the purpose

of employer's business, she had deviated from that course and was on an errand of her own at the time of the collision. In cases involving such deviations "a split of opinion appears * * * with the majority still denying compensation, and the minority granting it." 1 Larson, *Workmen's Compensation Law*, § 19.35, 4-387 (1985).

> "[T]he minority cases are weakened by the fact that the rule often serves merely as an alternative ground of decision which the court thinks desirable on other grounds as well, and by the fact that the deviations are often rather small and come very near being independently justifiable." 1 Larson, *supra*, § 19.35, 4-390. (Footnote omitted.)

The majority appears to conclude that the deviation in this case is small and independently justifiable. Cases with factual circumstances similar to this case and in which compensation has been denied include: *Prudential Life Insurance Co. v. Spears*, 125 Ind App 21, 118 NE2d 813 (1954) (insurance salesman parked in front of an account's house, crossed the street to get a piece of wood at a cabinet factory and sustained a fatal fall on re-crossing the street); *Colwell v. Mosley*, 309 SW2d 350 (Ky 1958) (coal-truck driver, on his route between the mine and the tipple, was killed when his truck was struck by another truck as he maneuvered to get into position to pull his brother-in-law's stalled car); *Mills v. Standard Parts Service Co.*, 269 Minn 501, 131 NW2d 546 (1964) (claimant fell after leaving a restaurant where he had had lunch en route between two of his employer's business sites); *Lumbermen's Mut. Cars. Co. v. Dedmon*, 196 Tenn 94, 264 SW2d 567 (1951) (lumber inspector, en route from a mill to his hotel, was struck by a car when re-crossing a street after visiting a sporting goods store); and *Hill v. Dept. of Labor & Industries*, 173 Wash

[2] Other states have held that injuries sustained enroute to medical treatment for a compensable injury are compensable. *See, e.g., Camp v. Lockheed Electronics, Inc.*, 178 NJ Super 535, 429 A2d 615, *rev den* 434 A2d 1090 (1981); *Moreau v. Zayre Corp.*, 408 A2d 1289 (Me 1979); *Laines v. Workmen's Comp. Appeal Bd.*, 48 Cal App 3d 872, 122 Cal Rptr 139 (1975); *Bettasso v. Snow-Hill Coal Corp.*, 135 Ind App 396, 189 NE2d 833 (1963). We also recognize that other courts have reached the opposite result. *See* 1 Larson, *supra*, § 13.13 (1985).

575, 24 P2d 95 (1933) (street car operator was struck by a car while crossing from his stopped street car to mail a letter at a post office along his route).

When claimant sustained her injury in May, 1982, she was not on her way to the chiropractor for treatment; she had stopped on a side trip of her own to buy gasoline. In *Wood v. SAIF*, 30 Or App 1103, 1108, 569 P2d 648 (1977), *rev den* 282 Or 189 (1978), we said:

> "The principle we glean from *Larson* is that the Workers' Compensation Act concept of compensability for injuries sustained in the course of and arising out of employment includes

> injuries during activities *which are the direct and natural consequence of the original injury.*" (Emphasis supplied.)

Claimant's act of stopping for gasoline was not a "direct and natural consequence of [her] original injury." Because it was not, the injury sustained in the collision in the service station is not compensable. The Board should be affirmed. I therefore dissent.[1]

[1] The majority notes, almost in passing, that medical and personal injury benefits would be paid by the other driver's insurance carrier and that a "settlement was proposed." It fails to mention that claimant settled her claim with the carrier for $10,000 and executed a release discharging the other driver and his carrier and

> "any other other person, firm or corporation charged or chargeable with responsibility or liability * * * from and all claims, demands, damages, costs, expense, [and] loss of services * * * arising from any act or occurrence up to the present time and particularly on account of all * * * loss or damages of any kind already sustained or that I may hereafter sustain in consequence [of the May, 1982, collision]."

IN THE COURT OF APPEALS OF THE STATE OF OREGON

In the Matter of the Compensation of Mikel T. MacDonald, Claimant.

MACDONALD,
Petitioner,

v.

SAFEWAY STORES, INCORPORATED,
Respondent.

(WCB 84-03634, 84-03635; CA A41681)

Judicial Review from Workers' Compensation Board.

Argued and submitted June 8, 1987.

W. D. Bates, Jr., Eugene, argued the cause and filed the brief for petitioner.

Kenneth L. Kleinsmith, Portland, argued the cause and filed the brief for respondent.

Before Warden, Presiding Judge, and Joseph, Chief Judge and Van Hoomissen, Judge.

VAN HOOMISSEN, J.

Affirmed.

VAN HOOMISSEN, J.

Claimant seeks review of a Workers' Compensation Board order which reversed the referee's order setting aside employer's notice of claim closure and awarding penalties and attorney fees. He contends that the Board erred in concluding that the referee did not have jurisdiction to review the claim closure or, in the alternative, that he did not prove an aggravation. On *de novo* review, ORS 656.298, we affirm.

Claimant sustained a compensable low back injury on May 24, 1983, while working for employer as a grocery clerk. On June 3, Dr. Boyd, claimant's treating physician, released him for "limited duty" for a period of two weeks. He returned to Boyd's office on June 16 and was seen by Dr. Bross, who was filling in for Boyd. Bross reported that claimant was "gradually improving," prescribed physical therapy and encouraged him to cut down on his work schedule.

Claimant wanted to see a back specialist. The Lane County Medical Society referred him to Dr. Abel, who examined claimant on August 4. Abel did not refer claimant to a specialist, but instead referred him for physical therapy and released him for modified work limited to four days per week. Abel scheduled another appointment for August 18; however, claimant did not return.

Employer's insurer requested a closing examination. Claimant saw Boyd on September 1. Boyd recommended physical therapy and prescribed anti-inflamation medicine. He referred claimant to Dr. Tearse, a neurologist, who found that claimant's low back strain was "resolving satisfactorily." He scheduled him for physical therapy and for a follow-up examination with Boyd.

On October 8, Abel submitted a Form 828, indicating that claimant had not been in for a follow-up examination and that he had been medically stationary with no permanent impairment on August 4, the date of his last visit. On October 18, the insurer issued a Notice of Closure on the low back claim. On March 30, 1984, claimant requested a hearing on the closure.

In February, 1984, claimant sustained a new industrial injury to his right knee. On May 3, he saw Boyd, who noted that claimant's back condition would bother him as long

as his knee was bothering him. Boyd saw claimant on June 29 and noted that he had made little improvement and that he might have a herniated disc. He was allowed only limited duty work. On December 21, claimant saw Dr. Gorman, a chiropractor, who concluded that he was not medically stationary and that permanent impairment could not be determined. Gorman also treated him for cervical and thoracic conditions.

On April 18, 1985, the insurer denied the an aggravation claim; it also denied responsibility for the cervical and thoracic conditions. It refused to pay Gorman. Claimant requested a hearing on the denial. Gorman later reported that the cervical and thoracic conditions were a result of the low back condition and that there was no additional charge for treating those conditions in addition to the charge for the low back condition. The insurer again refused to pay Gorman.

After concluding that he had jurisdiction, the referee set aside the closure. He further found that employer was unreasonable in closing the claim and awarded penalties and attorney fees. Finally, he concluded that employer was unreasonable in refusing to pay Gorman and awarded additional penalties and attorney fees. On review, the Board concluded that the referee did not have jurisdiction over the closure issue and denied the alternative aggravation claim. It upheld the referee's decision with respect to the refusal to pay Gorman and upheld the penalty and attorney fee, but did not allow attorney fees for prevailing before the Board on that issue.

Claimant first contends that the Board erred in concluding that the referee did not have jurisdiction over the closure issue. He argues that the right to seek a determination order in these circumstances is in addition to the right to request a hearing at any time on any matter. ORS 656.283(1). He relies on *Logue v. SAIF*, 43 Or App 991, 607 P2d 750 (1979). Employer argues that the referee did not have jurisdiction, because ORS 656.268(3) requires a claimant to seek a determination order before seeking a hearing on a closure and that claimant's remedy was clearly spelled out to him in the Notice of Closure. It also argues that *Logue* does not change the result, because in that case a determination order had been issued, and the issue was whether reconsideration was required before requesting a hearing.

ORS 656.268(3) provides, in relevant part:

> "When the medical reports indicate to the insurer or self-insured employer that the worker's condition has become medically stationary and the insurer or self-insured employer decides that the claim is disabling but without permanent disability, the claim may be closed, without the issuance of a determination order by the Evaluation Division. The insurer or self-insured employer shall issue a notice of closure of such a claim to the worker and to the Workers' Compensation Department. The notice must inform the worker of the decision that no permanent disability results from the injury; of the amount and duration of temporary total disability compensation; of the right of the worker to request a determination order from the Evaluation Division within one year of the date of the notice of claim closure; of the aggravation rights; and of such other information as the director may require. Within one year of the date of the notice of such a claim closure, a determination order subsequently shall be issued on the claim at the request of the claimant * * *."

ORS 656.283(1) provides:

> "Subject to subsection (2) of this section and ORS 656.319, any party or the director may at any time request a hearing on any question concerning a claim."

ORS 656.319(4) provides:

> "With respect to objections to a determination under ORS 656.268(3), a hearing on such objections shall not be granted unless a request for hearing is filed within one year after the copies of the determination were mailed to the parties."

Before the 1979 statutory amendments, the Evaluation Division determined all claim closures involving any type of disability. Insurers could close only time-loss only claims.

In 1979, the legislature modified the procedure to allow insurers and self-insured employers to close all temporary disability claims. *See* Minutes, Senate Committee on Labor, Consumer and Business Affairs, April 3, 1979, 4-6, 15. That procedure allows insurers and self-insured employers to close a claim without a prior determination order. If a claimant believes that the claim should not have been closed or that the claimant is entitled to permanent disability, he then *must* seek a determination order from the Evaluation Division. *See* Minutes, Senate Committee on Labor, Consumer and Business Affairs, April 3, 1979, 3-4; *see also* Exhibit A to Senate Bill 48, House Labor Committee, May 24, 1979, 4. The statute gives

the claimant the right to a review by the Evaluations Division and only then, if still dissatisfied, to a hearing. A determination order is not in addition to a hearing, but is one required before the employe seeks a hearing.

Claimant's reliance on *Logue v. SAIF, supra,* is misplaced. In that case, the Division had issued a determination order. We held that a claimant need not seek reconsideration of a determination order before seeking a hearing. In this case, no determination order has been issued. In fact, *Logue* supports a conclusion opposite to that which claimant advocates:

> "The Evaluation Division is distinct from the Hearings Division. The Evaluation Division has the responsibility for initially evaluating claims and issuing determination orders. ORS 656.708(2). The Hearings Division has the responsibility for conducting hearings and deciding all cases. ORS 656.708(3)." 43 Or App at 998.

Because the divisions are distinct and serve different purposes, it does not make sense that a claimant may go to either one for an initial determination of whether the insurer's or self-insured employer's closure was proper.

ORS 656.268(3) requires that a Notice of Closure notify a claimant of the right to request a determination order from the Evaluation Division but says nothing about notice of a right to a hearing. If the legislature had intended a claimant to have that option, the notice would presumably be required to say so.[1] The Board correctly determined that the referee lacked jurisdiction over the closure.[2]

Claimant contends that the Board erred in concluding that he did not prove an aggravation. He argues that he proved a worsening of his low back condition after the closure.

Boyd's June 29, 1984, report shows that he was treating claimant for "intermittent trouble" and that his low back strain had been improving for about a year and was "slowly resolving."

[1] ORS 656.268(3) has been amended by the 1987 legislature. Effective January 1, 1988, an insurer or self-insured employer may close any claim in which the worker has returned to work, whether it involves permanent or temporary disability, and a notice must inform the claimant *both* of the right to seek a redetermination by the Evaluation Division *and* of the right to request a hearing within 180 days of the Notice of Closure. House Bill 2900, § 10.

[2] Claimant also contends that the Board erred in finding that the Notice of Closure was proper and in reversing the referee's award of penalties and attorney fees for improper closure. Because we conclude that neither the referee nor the Board, had jurisdiction over the closure issue, we need not address those issues.

That report does not indicate that claimant's condition had worsened or that there was any increased disability. The medical records indicate that claimant returned to Boyd only after his later knee injury and that the recurrent back symptoms could be expected as long as he was having knee problems. He was not working and was receiving temporary disability benefits for the knee condition. We agree with the Board that claimant has not proven an aggravation.

Claimant contends that the Board erred in failing to award attorney fees for prevailing on employer's appeal of the penalty and attorney fees that the referee awarded for employer's unreasonable failure to pay Gorman. He argues that, because the Board agreed that the failure was unreasonable and agreed that a penalty and attorney fees were appropriate, he also was entitled to attorney fees on Board review. We have previously held that penalties and attorney fees are not compensation within the meaning of ORS 656.382, the statute allowing recovery of attorney fees for, *inter alia*, prevailing on Board review. *Saxton v. SAIF*, 80 Or App 631, 723 P2d 355, *rev den* 302 Or 159 (1986); *Bahler v. Mail-Well Envelope Co.*, 60 Or App 90, 652 P2d 875 (1982); *Mobley v. SAIF*, 58 Or App 394, 648 P2d 1357 (1982). We find no error.

Affirmed.

IN THE COURT OF APPEALS OF THE STATE OF OREGON

In the Matter of the Compensation of Dennis E. Naught, Claimant.

NAUGHT,
Petitioner - Cross-Respondent,

v.

GAMBLE, INC./PEPSI COLA, INC. et al,
Respondents - Cross-Petitioners,

and

GAMBLE, INC./PEPSI COLA, INC. et al,
Respondents - Cross-Respondents.

(WCB 84-02671, WCB 84-04467 & WCB 84-09197; CA A37391)

Judicial Review from Workers' Compensation Board.

Argued and submitted November 24, 1986.

Kenneth Bourne, Portland, argued the cause and filed the brief for petitioner - cross-respondent.

Jerald P. Keene, Portland, argued the cause for respondents - cross-petitioners. With him on the brief was Roberts, Reinisch & Klor, P.C., Portland.

Patric J. Doherty, Portland, argued the cause for respondents - cross-respondents. With him on the brief were Karli L. Olson and Rankin, McMurry, VavRosky & Doherty, Portland.

Before Richardson, Presiding Judge, and Newman and Deits, Judges.

RICHARDSON, P. J.

Affirmed on petition and cross-petition.

RICHARDSON, P. J.

Claimant seeks review of the Workers' Compensation Board's dismissal of a portion of his aggravation claim on the ground that his request for hearing was untimely. Employer's insurer, EBI Companies, asserts in its cross-petition that claimant's remaining aggravation claim constitutes a new injury for which EBI is not responsible. We affirm on the petition and cross-petition.

Claimant sustained a compensable injury to his upper back while working for Dr. Pepper Bottling Co. on June 16, 1980. The claim was processed by Dr. Pepper's insurance carrier, EBI. Claimant missed work for a brief period. The Workers' Compensation Department issued a determination order for time loss only in September, 1980. In November, 1980, Dr. Pepper was transferred to Pepsi Cola, Inc., owned by Gamble, Inc. Pepsi became self-insured on January 1, 1982, with Fred S. James & Co. (James) as its claim processor. Claimant continued to experience back pain, and states that he began to notice muscle tightening and pain in his lower back. The back condition became more bothersome with time, and he began chiropractic treatment in September, 1983. The chiropractor issued authorizations for absence from work from January 16, 1984, to March 19, 1984. EBI treated those written authorizations as an aggravation claim and issued a denial on March 1, 1984:

> "We acknowledge your request for reopening of this claim for worker's compensation benefits due to a worsening of your condition. At this time, we must respectfully deny your claim for aggravation due to the following legal and factual reason: Your present condition is not a continuation of your June 16, 1980 injury but a new injury. Without waiving other reasons, this denial is made."

Claimant submitted a timely request for a hearing pursuant to ORS 656.319 and filed a claim for a new injury with his employer. James denied the claim in March, 1984, stating that the injury had occurred before Pepsi became self-insured. Claimant also requested a hearing on that denial. On March 14, 1984, Drs. Buttler and McMahon, chiropractors, sent examination reports to EBI. They had diagnosed a primary, persistent sprain and strain in the upper back with a "spreading syndrome" to the cervical and lumbosacral areas.

Subsequent medical examinations by other physicians indicated that claimant also suffered a carpal tunnel syndrome in a wrist.

EBI was designated as the paying agent under ORS 656.307. That order dealt only with claimant's upper back and specifically excluded EBI's time loss payments for the lower back and the wrist. On May 24, 1984, EBI issued a second

denial, this time specifically referring to claimant's low back and wrist:

> "We acknowledge receipt of a formal claim for workers' compensation benefits for your low back and carpal tunnel conditions. At this time, we deny responsibility of the low back condition as it is not an aggravation or continuation of your June, 1980 injury but a new injury. We also deny compensability of your wrist condition as it did not arise out of and in the course and scope of your employment, nor is it related to the June, 1980 injury. In the alternate, we deny responsibility of your wrist condition as it is not a continuation of the June, 1980 injury but a new injury."

Claimant did not file a request for hearing on that denial. James issued six denial letters between May and October, 1984, each denying with increasing precision claimant's wrist and lower back conditions. Claimant requested a hearing on each of those denials.

The requests for hearings and the issue of carrier responsibility were consolidated. The referee concluded that claimant's upper and lower back conditions constituted an aggravation of his 1980 injury and that EBI was responsible. The portion of the claim involving the carpal tunnel condition was dismissed due to insufficient proof. In response to EBI's argument that claimant had failed to make a timely hearing request for his lower back and wrist conditions, the referee held that the failure was due to good cause: "The insurance change, the anatomic diversity of the problems, the sequence of events, number of doctors and complexity of treatments—all contributed to whatever failure, if any, occurred."

The Board affirmed the referee's holding on the responsibility issue with respect to the upper back; however, it reversed the referee's conclusion that claimant had established good cause under ORS 656.319 for his failure to request

a hearing challenging EBI's May 24, 1984, denial of the low back condition.

An employer has an obligation to pay interim compensation or to issue a denial within 14 days of receiving a claim. ORS 656.262. A claimant has a corresponding obligation to request a hearing in response to each denied claim in order to place the denial before a referee. ORS 656.319(1). Claimant asserts that the Board erred in treating his lower back condition as an independent claim which was not encompassed in EBI's initial general denial and which was, therefore, included in claimant's hearing request. A key inquiry here, then, is the scope of claimant's original claim and the inclusive elements of any later claims.

Acceptance of a claim does not encompass conditions of which the employer had no knowledge or notice at the time of acceptance. *Gregg v. SAIF*, 81 Or App 395, 725 P2d 930 (1986); *Destael v. Nicolai Co.*, 80 Or App 596, 601, 723 P2d 348 (1986); *see Johnson v. Spectra Physics*, 303 Or 49, 733 P2d 1367 (1987). It follows, then, that an employer's denial does not encompass claims or conditions of which the employer had no knowledge at the time of denial. EBI elected to treat a physician's note excusing claimant from work as an aggrava-

tion claim. At the time when it issued its initial denial, it had no notice of claimant's lower back condition. The medical records at that juncture documented only the upper back condition.

The Board classified Buttler's and McMahon's medical report of March 14 as stating a new and independent claim and a separate claim for aggravation. ORS 656.273. That report provided EBI with its initial notice of the lower back condition. This case is factually different from *Rater v. Pacific Motor Trucking Co.*, 77 Or App 418, 713 P2d 651 (1986), where we concluded that the claimant's medical report was merely "proffered evidence" supporting an existing claim rather than a new and independent claim. There, the contested report merely related additional details regarding conditions and injuries of which the employer was already aware. In this case, the March 14 report stated a new condition, lower back pain, which is not reasonably encompassed by a claim for upper back distress. EBI's second denial on May 24, 1984, was not merely redundant with respect to the lower back, as claimant

argues, but fulfilled the insurer's obligation under ORS 656.262. By neglecting to request a hearing within 60 days in response to the second denial, claimant failed to place EBI's denial of the lower back condition in issue, and the referee had no jurisdiction to address the merits of that claim.

The remaining question is whether claimant had "good cause" under ORS 656.319(1)(b) for not filing a timely hearing request. "Good cause" means the same kind of "mistake, inadvertence, surprise or excusable neglect" that would also permit relief from a default judgment under ORCP 71B or *former* ORS 18.160. *Brown v. EBI Companies*, 289 Or 455, 616 P2d 457 (1980); *Sekermestrovich v. SAIF*, 280 Or 723, 573 P2d 275 (1977); *Anderson v. Publishers Paper Co.*, 78 Or App 513, 717 P2d 635, *rev den* 301 Or 666 (1986). 176 days expired between the time of EBI's second denial and the date of the hearing before the referee in the present case, which is when claimant requested a hearing on the second denial. Although the number of parties and denials could have produced some confusion, claimant did not contend or prove that confusion caused his failure to submit a timely hearing request. Instead, he presented a legal theory *excusing* the filing of a request, which the Board rejected and which is not before us now.

Claimant bears the burden of showing good cause for failure to file a hearing request. *Cogswell v. SAIF*, 74 Or App 234, 237, 702 P2d 81 (1985). He has failed to meet that burden. The Board properly ruled that the referee lacked jurisdiction to hear the lower back claim. .

In its cross-petition, EBI argues that claimant's work conditions after the 1982 change of insurers sufficiently contributed to the worsening of his mid- and upper back conditions sufficient to shift responsibility to the self-insured employer. EBI produced several witnesses who testified at length about claimant's duties and general work conditions at Pepsi after the change of insurers. The referee found that "lay evidence establishes that claimant's duties were not as strenuous as claimant stated them to be." The Board apparently concurred in that finding. When the credibility of witnesses is

at issue, we give great weight to the observations of the referee, who had the advantage of seeing and hearing the witnesses. *Miller v. Granite Construction Co.*, 28 Or App 473, 559 P2d 944

(1977); *Fredrickson v. Grandma Cookie Co.*, 13 Or App 334, 337-38, 509 P2d 1213 (1973). On *de novo* review we find no reason to dispute the referee's findings. We agree that claimant's work after 1982 did not contribute to his condition.

Affirmed on petition and cross-petition.

IN THE COURT OF APPEALS OF THE STATE OF OREGON

HIGHFIELD,
Respondent,
v.
HOFFMAN CONSTRUCTION COMPANY,
Appellant.
(A8307-04563; CA A37604 (Control))

HIGHFIELD,
Respondent,
v.
HOFFMAN CONSTRUCTION COMPANY,
Appellant.
(A8503-01695; CA A37605)
(Cases consolidated)

Appeal from Circuit Court, Multnomah County.

Robert Redding, Judge.

Argued and submitted June 22, 1987.

John R. Faust, Jr., Portland, argued the cause for appellants. With him on the briefs was Schwabe, Williamson, Wyatt, Moore & Roberts, Portland.

Wayne Mackeson, Portland, argued the cause for respondents. With him on the brief was Des Connall and Dan Lorenz, P.C., Portland.

Before Warden, Presiding Judge, and Van Hoomissen and Rossman, Judges.

VAN HOOMISSEN, J.

Judgment affirmed in each case.

VAN HOOMISSEN, J.

Plaintiffs brought this action for negligence based on violations of common law standards of care and on violations of the Employers' Liability Act (ELA). ORS 654.305 *et seq.* Defendant appeals from judgments on jury verdicts in favor of plaintiffs. We affirm.

Plaintiff[1] was injured when he fell two floors from a building under construction. His second amended complaint

alleged, as a first claim for relief, that defendant was negligent in several particulars. He then alleged, as a second claim, that defendant, in several particulars,

> "failed to use every device, care and/or precaution which it is practicable to use for the protection and safety of life and limb and failed to provide [plaintiff] with a place which was safe."

That amounted to a claim that defendant had violated its duties under the ELA. ORS 654.305. Following a partial directed verdict for plaintiff regarding defendant's failure to provide access between floors, the trial court instructed the jury regarding both the negligence claim and the ELA claim. The jury returned a verdict that stated, in relevant part:

> "We, the jury, find:
>
> "(1) Did the defendant violate the Employers Liability Law in one or more of the particulars alleged in plaintiff's complaint, and, if so, was such violation a cause of damage to plaintiff?
>
> "ANSWER: ___ Yes ___ No.
>
> "(2) Was defendant negligent in one or more of the particulars alleged in plaintiff's complaint, and, if so, was such negligence a cause of the injuries claimed by plaintiff?
>
> "ANSWER: ___ Yes ___ No.
>
> "* * * * *
>
> "(5) What are plaintiff's total general and special damages?
>
> "ANSWER: General damages: $*1,000,000.00*
>
> "Special damages: $*121,000.00*."

The presiding juror circled the words "yes" in answer to questions (1) and (2) and signed the verdict form.[2]

Defendant's assignments of error all challenge the appropriateness of the court's rulings regarding the ELA claim. It assigns error to the ruling granting the directed verdict regarding the failure to provide ladders, the refusal to allow it to argue the question of control and the instructions about ELA liability. Nowhere does defendant challenge the rulings or instructions regarding the claim for common law negligence. As a result, even if defendant is correct about its assignments of error under the ELA, the jury's verdict is still independently supported under the common law negligence claim. Therefore, we affirm the trial court.

Defendant's appeal from the judgment in favor of Barbara Highfield suffers from the same flaw. That judgment is also affirmed.

Judgment affirmed in each case.

---

[1] Plaintiffs are Clarence Highfield, the injured worker, and his wife Barbara, who brought suit for loss of her husband's society and companionship. Unless otherwise stated, our reference to plaintiff throughout this opinion is to Clarence.

[2] Defendant concedes that, if the jury made a finding that defendant breached a duty owed to plaintiff in one or more of the particulars ultimately submitted to the jury, such a finding would independently support the jury verdict on plaintiffs' negligence claim. Defendant argues, however, that the jury never made any finding that defendant was negligent in any of the particulars; it contends that the jury simply found that defendant was negligent and that the quoted language comes from a special verdict form never signed by the presiding juror and which was received by the court on October 7, the day after the verdict was allegedly entered. Defendant is correct that the "special verdict" forms were not signed. However, the verdict form signed by the presiding juror contains the quoted language and was signed on October 3, and the judgment was entered on October 4 with an amended judgment on October 10.

IN THE COURT OF APPEALS OF THE STATE OF OREGON

In the Matter of the Compensation of Richard L. McGinnis, Claimant.

McGINNIS,
Petitioner,

v.

TIGARD SCHOOL DISTRICT #23J et al,
Respondents.

(WCB No. 85-08334; CA A42132)

Judicial Review from Workers' Compensation Board.

Argued and submitted June 1, 1987.

Randy Elmer, Salem, argued the cause for petitioner. With him on the brief was Vick & Gutzler, Salem.

Darrell E. Bewley, Assistant Attorney General, Salem, argued the cause for respondents. With him on the brief were Dave Frohnmayer, Attorney General, and Virginia L. Linder, Solicitor General, Salem.

Before Warden, Presiding Judge, and Van Hoomissen and Rossman, Judges.

ROSSMAN, J.

Affirmed.

ROSSMAN, J.

Claimant seeks review of a Workers' Compensation Board order affirming the referee's decision that his request for hearing on a determination order was untimely. We affirm.

Claimant sustained a compensable injury in August, 1983. On July 6, 1984, SAIF filed a Form 1503, "Insurer's Determination Request," with the Evaluation Division of the Workers' Compensation Department. On July 19, 1984, the Division issued a determination order granting claimant temporary total disability, temporary partial disability and permanent partial disability. On August 7, 1984, SAIF filed a second determination request form and included with it a recent medical report which had not been available at the time of the first request. On August 16, 1984, the Division issued a second determination order, which stated that the additional medical information did not introduce any material which would require a modification of the first determination order. Both the first and second determination orders contained printed language advising claimant that a request for hearing must be filed within one year from the date of mailing of an order.

Claimant filed a request for hearing on August 9, 1985, more than one year after the first determination order, but less than one year after the second order. Both the referee and the Board dismissed the request as untimely, relying on ORS 656.268(4), which provides, in part:

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

The Board reasoned that SAIF's August determination request sought reconsideration of the July determination order and that the August order was an order on reconsideration of the July order. Applying the last sentence of ORS

656.268(4), the Board stated that the request for reconsideration extended by nine days, to July 28, 1985, the time period for filing a request for hearing from the first determination order. Because claimant's request for hearing was not filed until August 9, 1985, the Board concluded that it was untimely and affirmed the referee's dismissal.

Claimant first asserts that SAIF's August request was not a request for reconsideration, but merely a transmittal of materials, and that SAIF used Form 1503 only for convenience. He asserts additionally that the August determination order was not a reconsideration of the July determination order but an "original" determination order, from which a hearing on the questions of disability and time loss could be sought and from which the one-year time limit of ORS 656.268 began to run.

In its second determination request, under the section entitled "Reason for filing this form," SAIF checked the box marked "Additional information since previous request." It did not check the box marked "Reconsideration of previous determination order is requested." We conclude, however, that the Division should not be limited in its ability to reexamine a claim by the precise language that a party uses or does not use in a determination request form. The fact that SAIF did not expressly indicate that it was seeking reconsideration should not preclude the Division from reconsidering its prior award based on the additional information, if appropriate. Although the second determination order does not use the word "reconsideration," it does, in fact, reconsider the first order and conclude that no change is necessary. It does not independently address the questions of extent and time loss and makes no independent determination of benefits and no adjustment to the previous award. We conclude that the second determination order was a reconsideration of the first, pursuant to ORS 656.268(4), and that it extended by nine days, to July 28, 1985, the time for seeking a hearing on the issues decided by the first determination order.[1] Claim-

[1] This case is distinguishable from *Int'l Paper Company v. Tollefson*, 86 Or App 706, ___ P2d ___ (1987), where we held that, when the Board, as opposed to the Evaluation Division, withdraws its initial order and then adheres to and republishes it, the date of the republication is the date from which the 30-day period for seeking review runs. There is no statute comparable to ORS 656.268(4) dealing with Board reconsideration of its own order.

ant's August 9, 1985, request for hearing was therefore untimely as to those issues. The request would have been timely, however, as to the one issue decided by the second determination order: whether the additional medical information submitted by SAIF requires a change in the award. There is no indication that claimant sought to place that issue before the referee.

Claimant asserts in the alternative that, by waiting until August 8, 1985, to file his hearing request on the issues decided by the first determination order, he reasonably relied on an allegedly misleading notice printed on the second determination order form, which stated that he had one year from the date of the mailing of that order within which to request a hearing. Claimant does not argue a theory of estoppel, and we need not consider whether that doctrine could apply here. Neither does he cite any statutory basis for a waiver of the filing requirement. *See, e.g.*, ORS 656.319(1)(b). However, even if claimant's theory of reasonable reliance could apply to excuse a late request, we conclude that the argument does him no good here. As our discussion of his first contention suggests, the notice printed on the second determination order was not incorrect. It properly advised claimant that he could request a hearing within one year. However, because the second determination order provided no independent basis for a review of the award made by the first order, it was not reasonable for claimant to assume that a request for hearing which was timely only as to the second order would encompass the issues decided by the first. The Board correctly held that it could not decide the questions of extent and time loss addressed in the first determination order.

Affirmed.

---

390 September 9, 1987 No. 541

IN THE COURT OF APPEALS OF THE STATE OF OREGON

In the Matter of the Compensation of Annetta R. McKinstry, Claimant.

McKINSTRY,
Petitioner,

v.

INDUSTRIAL INDEMNITY et al,
Respondents.

(WCB 85-09657; CA A42515)

Judicial Review from Workers' Compensation Board.

Argued and submitted July 24, 1987.

Robert Wollheim, Portland, argued the cause for petitioner. With him on the brief was Welch, Bruun & Green, Portland.

Patric J. Doherty, Portland, argued the cause for respondents. With him on the brief was Scott M. Kelley, Portland.

Before Warden, Presiding Judge, and Van Hoomissen and Young, Judges.

PER CURIAM

Reversed and remanded with instructions to accept claim.

PER CURIAM

The sole issue in this workers' compensation case is whether claimant's stress-related mental disorder is a compensable occupational disease. The Workers' Compensation Board affirmed the referee's finding that it is not compensable, and claimant seeks review. We review *de novo,* ORS 656.298, and reverse.

To establish the compensability of her stress-related disorder, claimant had to prove that stressful conditions objectively existed on the job at employer's workplace and that the employment conditions, when compared to non-employment exposure, were the major contributing cause of the disorder. *McGarrah v. SAIF,* 296 Or 145, 166, 675 P2d 159 (1983). Here, the undisputed testimony, including that of claimant's supervisor, is that the conditions at employer's workplace were stressful. The uncontradicted medical evidence is that claimant suffers from a stress-related mental disorder whose major, if not sole, contributing cause is the employment conditions. Applying the *McGarrah* standards, we hold that claimant's condition is compensable.[1]

Reversed and remanded with instructions to accept the claim.

[1] Because claimant has made no claim against her later employer and employer here has not sought to join the later employer in these proceedings, this employer cannot avoid responsibility for payment of compensation by showing that working conditions at the later employment contributed to claimant's disability. *Runft v. SAIF,* 303 Or 493, 495, 739 P2d 12 (1987).

IN THE COURT OF APPEALS OF THE STATE OF OREGON

In the Matter of the Compensation of Perry W. Hobson, Claimant.

HOBSON,
Petitioner,

v.

ORE DRESSING, INC. et al,
Respondents.

(WCB 84-01772; CA A38970)

Judicial Review from Workers' Compensation Board.

Argued and submitted December 5, 1986.

James L. Edmunson, Eugene, argued the cause for petitioner. With him on the brief was Malagon & Moore, Eugene.

Margaret E. Rabin, Assistant Attorney General, Salem, argued the cause for respondents. On the brief were Dave Frohnmayer, Attorney General, Virginia L. Linder, Solicitor General, and Christine Chute, Assistant Attorney General, Salem.

Before Richardson, Presiding Judge, and Newman and Deits, Judges.

RICHARDSON, P. J.

Affirmed.

RICHARDSON, P. J.

In this workers' compensation case, claimant seeks review of the Board's denial of a claim for benefits arising out of claimant's injury in California. The Board adopted the referee's opinion, which held that claimant was not a covered worker, because he did not work for an Oregon employer covered by the Workers' Compensation Act. We affirm.

Claimant is the president and a 50 percent shareholder of an Oregon corporation known as Ore Dressing, Inc. Before their move to California in 1983, claimant and his wife operated the business out of their Oregon home. Ore Dressing was originally formed in 1975 to operate a zirconium reclamation plant in Portland, but that project terminated and the company subsequently developed a gold reclamation site in Siskiyou County, California. Claimant and his wife sold their Portland home and rented a house near the California reclamation site in late summer, 1983. Oregonians were recruited to dismantle the reclamation plant in Portland and to move it to California and operate it. Dismantling of the plant began in August, 1983. The move to California began on October 1 and required about 10 days. Claimant was injured while setting up the new plant in California on October 14, when a self-propelled machine that he was operating went out of control and overturned.

In September, 1983, Ore Dressing renewed its workers' compensation coverage that it had been carrying with SAIF and the policy covered claimant as a corporate officer. Gene Hobson, secretary of the corporation and also a 50 percent shareholder, informed SAIF prior to the renewal that the corporation would be employing Oregon workers in California. She did not inform SAIF that Ore Dressing's corporate headquarters had moved to California.[1] The policy expressly limits coverage to injuries which are compensable under the Oregon Workers' Compensation Law. On November 7, 1983, SAIF denied the claim, because claimant was not an Oregon employe to whom its coverage applied. The referee and the Board upheld SAIF's denial.

ORS 656.126(1) entitles "a worker employed in this state" who "temporarily leaves the state incidental to employment" to coverage under the Oregon Workers' Compensation Law. A key inquiry is the extent to which the claimant's work outside the state is temporary. *Phelan v. H.S.C. Logging, Inc.*,

[1] The corporation's policy renewal application listed work sites in Portland and California but did not mention that the corporation's base of operations had moved from Oregon to California.

84 Or App 632, 735 P2d 22, *rev den* 303 Or 590 (1987); *Wright v. Industrial Indemnity Co.*, 68 Or App 302, 680 P2d 1018 (1984); *Langston v. K-Mart*, 56 Or App 709, 642 P2d 1205, *rev den* 293 Or 235 (1982). Claimant argues that his employment in California was "temporary" and "merely incidental to Oregon employment," because he intended to return to Oregon once the Siskiyou project was completed. That argument is unpersuasive. The record indicates that when claimant moved to California, Ore Dressing moved with him. As already noted, the corporation's headquarters were located in claimant's California home after August, 1983, and the company paid payroll taxes to California for claimant. Following the move, the former Portland work site was effectively inactive, and the corporation's contacts in Oregon were limited to claimant's trips into the state to negotiate future projects and consult with accountants, lawyers and financial institutions. As the referee concluded, at the time of claimant's accident "there was no longer an Oregon employer for which the work in California could be incidental."

Claimant argues alternatively that SAIF should be "equitably estopped" from denying coverage. Even assuming that coverage of an otherwise noncompensable injury could be imposed on the theory of equitable estoppel, we conclude that claimant has not proven an estoppel, which requires proof of some material misrepresentation by SAIF and claimant's reasonable reliance. *Johnson v. Kentner*, 71 Or App 61, 72, 691 P2d 499 (1984), *rev den* 299 Or 31 (1985). Claimant has not shown any false representations. Gene Hobson testified that she "assumed" that SAIF's issuance of a policy in September, 1983, meant that claimant was covered. SAIF was not informed that Ore Dressing had moved to California, and so renewal of the policy could not be a representation that employes would be covered under those circumstances. Ore Dressing's failure to obtain worker's compensation coverage was a product of a misunderstanding rather than a misrepresentation.

Affirmed.

IN THE COURT OF APPEALS OF THE STATE OF OREGON

In the Matter of the Compensation of Daryl G. Richmond, Claimant.

RICHMOND,
Petitioner,
v.
SAIF CORPORATION et al,
Respondents.

(WCB 83-08780; CA A39405)

Judicial Review from Workers' Compensation Board.

On petitioner's petition for reconsideration filed June 23, 1987. Former opinion filed May 20, 1987, 85 Or App 444, 737 P2d 135.

Philip H. Garrow, Bend, for petition.

Before Richardson, Presiding Judge, and Newman and Deits, Judges.

RICHARDSON, P. J.

Petition for reconsideration allowed; former opinion adhered to as clarified.

RICHARDSON, P. J.

Claimant petitions for review of our decision, 85 Or App 444, 737 P2d 135 (1987), and we treat the petition as one for reconsideration. ORAP 10.10. We allow reconsideration and adhere to our decision as explained in this opinion.

One issue in this case is whether SAIF had accepted responsibility for claimant's psychological condition before the disputed claim settlement under ORS 656.289(4). Claimant was receiving benefits for a back injury. After an initial determination order, the parties stipulated to reopen the claim "for temporary total disability and medical service benefits effective November 9, 1981, and continuing until closed." SAIF then began paying for claimant's psychological care. In our opinion we said:

> "Claimant asserts that, because SAIF agreed to reopen the claim and paid for claimant's psychological care from December, 1981, through May 23, 1983, it has accepted the psychological condition. Claimant is incorrect. ORS 656.262(9) provides in part:
>
> > " 'Merely paying or providing compensation shall not be considered acceptance of a claim or an admission of liability * * *.'
>
> "Additionally, it has been established that payments made by an insurer in compliance with ORS 656.262(4) are not to be interpreted as acceptance of a claim." 85 Or App at 447. (Footnote omitted.)

Claimant notes, in his petition, that ORS 656.262(6) provides:

> "Pending acceptance or denial of a claim, compensation payable to a claimant does not include the costs of medical benefits."

Medical benefits, he contends, are not interim compensation which must be paid under ORS 656.262(4) and that we were incorrect in suggesting that they are. It follows, he argues, that payment of medical benefits by SAIF was not required but was voluntary in acknowledgment of responsibility for the psychological condition. Consequently, he postulates, payment of the medical costs do not come under ORS 656.262(9), because they are not "interim compensation."

Medical payments made by an employer or carrier are

not "interim compensation." In *Jones v. Emanuel Hospital*, 280 Or 147, 570 P2d 70 (1977), the court used the term "interim compensation" as being effectively synonymous with temporary total disability. Although we agree with claimant that medical payments are not the same as temporary total disability benefits, we do not agree that the payment of benefits by SAIF in this case constituted an acceptance of the psychological condition as compensable. ORS 656.262(9) does not relate only to "interim compensation."

Petition for reconsideration allowed; former opinion adhered to as clarified.

IN THE COURT OF APPEALS OF THE STATE OF OREGON

REA,
Respondent,
v.
UNION PACIFIC RAILROAD COMPANY,
Appellant.
(A8406 03370; CA A42807)

Appeal from Circuit Court, Multnomah County.

Harl H. Haas, Judge.

Argued and submitted August 14, 1987.

Austin W. Crowe, Jr., Portland, argued the cause for appellant. On the briefs were Thomas W. Brown and Cosgrave, Kester, Crowe, Gidley & Lagesen, Portland.

Thomas M. Christ, Portland, argued the cause for respondent. With him on the brief were Thomas Schnieger and Monte Bricker, Portland.

Before Richardson, Presiding Judge, and Newman and Deits, Judges.

RICHARDSON, P. J.

Affirmed.

RICHARDSON, P. J.

Defendant appeals from the trial court's judgment for plaintiff in this action under the Federal Employers Liability

Act, 45 USC § 51 (FELA). Plaintiff was employed by defendant at its yard in Hinkle, Oregon. He alleges that he has suffered a hearing loss and tinnitus due to repeated exposure to the shrill, loud noise emitted when railway cars are rolled or pulled through retarders in the yard. Through its answer and its in-court admissions, defendant agreed that it was negligent, that some of plaintiff's hearing loss was caused by the retarder noise and "that loud sounds such as the retarder *can* cause tinnitus." (Emphasis supplied.) Defendant did not admit that plaintiff *does* suffer tinnitus, and it asserts that plaintiff's hearing loss was due in part to other causes as well as the retarder noise.

Defendant assigns 13 errors, one of which it has withdrawn. Nine of the remaining 12 relate to the trial court's admission of evidence proffered by plaintiff and the other three to the court's denial of defendant's mistrial motions. There is little merit to any of the assignments. Several of them are predicated on defendant's understanding that evidence was admitted which tended to prove liability or misconduct on defendant's part and that such evidence should not have been received, because fault was admitted and the only "issues in this case were ones of medical, scientific or audiological causation." We do not agree that defendant's admissions narrowed the relevant factual considerations to the extent that defendant suggests. Defendant did not admit that plaintiff suffered from tinnitus at all, and our understanding of its concession is that it left the factfinder free to find that much or most of the hearing loss was caused by things other than retarder noise. The fact that defendant admitted fault did not make evidence which was probative of fault inadmissible if it was also relevant to the cause of plaintiff's hearing loss and to whether and why he has tinnitus. We will discuss one of defendant's specific assignments to illustrate why we do not agree with its understanding about the effect that its admissions had on what issues were in the case and what evidence was relevant to them.[1]

Plaintiff introduced a videotape with a recording of the retarder noise. That recording was played for the jury. Defendant assigns error to its admission and argues:

> "Defendant admitted that the retarders emitted extremely loud sounds and that those sounds caused, in part, plaintiff's hearing loss and could cause tinnitus. Thus, as noted, the only issues in dispute were ones of *medical, scientific or audiological causation,* which were necessarily the subject of expert testimony. More particularly, it was for the various experts to determine, based upon knowledge and understanding of the frequency and [decibel] levels of defendant's retarders, and the auditory effects of those factors, whether all or part of plaintiff's hearing loss was defendant's responsibility, whether plaintiff had tinnitus and if so, whether his tinnitus was in whole or in part defendant's responsibility. Presentation of the retarder sounds to the jury could not in any way have made those facts of consequence more or less probable than it would be without the evidence. Therefore, the evidence should have been excluded.
>
> "Defendant has not located any case on point. What plaintiff in essence obtained was a sensory reproduction of the

[1] We also discuss that assignment because, the parties give us to understand, there are many related cases pending in the circuit court, and the assignment relates to an issue which many of the cases may have in common. *See Blankenship v. Union Pacific Railroad Co.*, 87 Or App 410, ___ P2d ___ (decided this date).

tortious conduct or *event* in the courtroom. Thus, under plaintiff's rationale, a jury in an automobile accident case would need to be physically exposed to the exact impact in order to determine whether all or part of plaintiff's injuries were accident related or related to other possible causes. In an assault case, each juror would have to be subjected to the same physical blows as the plaintiff to determine whether plaintiff's complaints were caused by such contact. In a slip and fall case, each juror would need to 'relive' plaintiff's fall in order to properly determine whether alleged injuries were accident related." (Emphasis defendant's.)

We do not share defendant's view that the need for expert testimony concerning the causal effects of an event means that direct evidence that the event occurred is irrelevant to causation or is cumulative. It may be that playing the recording to the jury would not have been *sufficient* evidence of causation without expert testimony. However, the converse is not correct. Plaintiff was entitled to present evidence of what happened as well as presenting expert evidence analyzing the effects of what happened.

Defendant's argument that playing the recording is analogous to abusing the jurors physically in an assault case is

a *reductio ad absurdum*. It would be far more accurate to analogize the evidence to a photograph of an assault taken by a photographer who had caught the defendant in the act.

Defendant argues alternatively that the probative value of the recording was outweighed by its potential prejudicial effect. We disagree, and we reject its assignment concerning the playing of the recording. Its other assignments do not demonstrate reversible error and do not require further discussion.

Affirmed.

IN THE COURT OF APPEALS OF THE STATE OF OREGON

BLANKENSHIP,
Respondent,
v.
UNION PACIFIC RAILROAD COMPANY,
Appellant.

(A8506 03654; CA A43143)

Appeal from Circuit Court, Multnomah County.

James R. Ellis, Judge.

Argued and submitted August 14, 1987.

Austin W. Crowe, Jr., Portland, argued the cause for appellant. On the briefs were Thomas W. Brown and Cosgrave, Kester, Crowe, Gidley & Lagesen, Portland.

Thomas M. Christ, Portland, argued the cause for respondent. With him on the brief was Thomas Schneiger, Portland.

Before Richardson, Presiding Judge, and Newman and Deits, Judges.

RICHARDSON, P. J.

Affirmed.

RICHARDSON, P. J.

Defendant appeals from the judgment for plaintiff in this FELA case, which is a companion to *Rea v. Union Pacific Railroad Co.*, 87 Or App 405, ___ P2d ___ (decided this date), and which involves essentially the same facts and claims. The principal difference between the two cases is that, here, defendant admitted in the trial court that it was negligent, that plaintiff had suffered a hearing loss and tinnitus and that its negligence was the sole cause of plaintiff's injuries. Hence, the only issues defendant did not concede are the nature and extent of plaintiff's injuries and the amount of damages.

As it does in *Rea v. Union Pacific, supra,* defendant assigns error to the playing to the jury of a videotape recording of retarder noise of the kind which caused plaintiff's hearing loss and tinnitus. Defendant also assigns as error, *inter alia,* the trial court's admission of the testimony of plaintiff and another witness about specific episodes of retarder noise to which plaintiff was exposed and admission of testimony relating to defendant's ear protection policies and measures. We held in *Rea* that the recording was admissible, because it was relevant to what caused the plaintiff's hearing loss and to whether and how he became afflicted with tinnitus. The recording and the other evidence relating to liability and causation were not admissible on that basis in this case, because those issues were not before the factfinder. Defendant is correct in arguing that that evidence was not relevant to any question of fact in the case and that its admission was error.

However, we conclude that the erroneously admitted evidence was not prejudicial and does not require reversal in this case.[1] Although defendant argues repeatedly and at some length that the evidence had the purpose and effect of blackening defendant in the jury's eyes, we think that the evidence did little if anything more than illustrate what defendant had admitted. Moreover, any prejudicial effect which the evidence might otherwise have had was dissipated by the court's careful definition of the issues which the jury was to consider. After

informing the jury of what defendant had admitted, the court instructed:

> "[T]he issues before you are relatively simple. First, your determination as to what is the extent and nature of the Plaintiff's hearing loss and extent and nature of [his] tinnitus. After you make that determination, you will then decide what sum of money is a reasonable award to the Plaintiff for his damages."[2]

[1] As we noted in *Rea v. Union Pacific Railroad Co., supra,* 87 Or App at ___, n 1, the parties advise us that there are a large number of related cases pending in the circuit court. Whether similar errors would be harmless in other cases is, of course, a question which would depend on the context in which they occur.

The admission of the evidence which these three assignments challenge was harmless error.

Defendant also assigns error to the court's refusal to give two requested instructions, the thrust of which was that plaintiff's damages for future pain and suffering should be reduced to present value. How such damages should be calculated in FELA cases is a question of federal law. *Geris v. Burlington Northern, Inc.*, 277 Or 381, 561 P2d 174 (1977). Defendant acknowledges that the majority view among the United States Circuit Courts of Appeals is contrary to its view and is that damages for future pain and suffering should not be computed on a present value basis. *See O'Byrne v. St. Louis Southwestern Ry. Co.*, 632 F2d 1285 (5th Cir 1980); *Flanigan v. Burlington Northern Inc.*, 632 F2d 880 (8th Cir 1980), *cert den* 450 US 921 (1981); *Taylor v. Denver and Rio Grande Western Railroad Co.*, 438 F2d 351 (10th Cir 1971). However, defendant urges us to adopt the minority view expressed in *DeChico v. Metro-North Commuter R.R.*, 758 F2d 856 (2nd Cir 1985), as better reasoned and, also, as more consonant with the general policy pertaining to the reduction to present value of other kinds of prospective damages.

There is no controlling United States or Oregon Supreme Court decision on the question. That being so, it is clearly within the *authority* of this court to adopt either position on the federal question, and we are not bound by what the majority of federal (or state) courts have held. It is also clear that, in deciding what the federal law is, the fact that a decided

preponderance of federal courts have taken one view rather than the other is a relevant consideration in itself, along with but independently of the persuasiveness of the reasoning which supports the two views. *See Geris v. Burlington Northern, Inc., supra.* Moreover, the rationale for each view on this question are at least comparably persuasive, and perhaps equally so. The majority view is based on the fact that the degree and timing of a plaintiff's future pain and suffering are so variable, unpredictable and unquantifiable that they are far less susceptible to a present value adjustment, either mechanically or as a realistic measure of compensation, than are damages for prospective pecuniary losses.[3] The rationale for the minority view is that all damages for prospective losses, regardless of their nature, should be equally subject to a "use of the money" adjustment, so that current awards will provide no more than actual compensation as of the time the injury is suffered. We accept the rule which the majority of the federal circuits have adopted, and we therefore hold that the trial court did not err by refusing to give the requested instructions.

Defendant's other assignments do not require discussion.

Affirmed.

[2] The court later instructed:

"[I]n considering damages in this case, you must first determine each of the items of Plaintiff's damages, * * * *provided you find that they have been suffered by him as a result of the Defendant's negligence* * * *." (Emphasis supplied.)

Neither party attributes error to the emphasized language.

[3] The court explained in *Chicago & N. W. Ry. Co. v. Candler*, 283 F 881, 884 (8th Cir 1922), that, unlike future pecuniary losses, "[i]n the matter of pain, suffering, or inconvenience, no books are kept, no inventories made, no balances struck."

IN THE COURT OF APPEALS OF THE STATE OF OREGON

In the Matter of the Compensation of Marco Aguiar, Claimant.

AGUIAR,
Petitioner,

v.

J. R. SIMPLOT COMPANY,
Respondent.

(84-05596; CA A39921)

Judicial review from Workers' Compensation Board.

Argued and submitted January 5, 1987.

Kenneth D. Peterson, Jr., Hermiston, argued the cause and filed the brief for petitioner.

Kenneth L. Kleinsmith, Portland, argued the cause for respondent. On the brief were Meyers & Terrall, and Daniel L. Meyers, Portland.

Before Richardson, Presiding Judge, and Newman and Deits, Judges.

DEITS, J.

Reversed and remanded with instructions to reinstate referee's order setting aside employer's partial denial of surgery and award of attorney fees and to rescind the May 15, 1984, determination order as prematurely closed.

DEITS, J.

Claimant seeks reversal of an order of the Workers' Compensation Board which held that his proposed surgery was not reasonable and necessary, that the claim was not prematurely closed and that claimant had suffered no permanent partial disability. We reverse and remand.

On March 31, 1983, while employed by respondent, claimant was injured when an aluminum irrigation pipe fell on his right foot.[1] The first treating physician was Dr. Carpenter, who diagnosed a ligament injury, which he treated with injections and casting. In June, claimant re-injured his foot while cleaning cattle pens. After four months, he was still experiencing pain and swelling. He was seen by Dr. Smith, an orthopedist, who found that the foot had a "purplish look," was tender and was painful. In October, employer sent claimant to Dr. Puziss, an orthopedic surgeon, who diagnosed a sinus tarsi syndrome and recommended a minor surgical procedure involving excision of the sinus tarsi fat pad.

Subsequently, employer sent claimant to Dr. Kiest and Dr. Weeks, also orthopedists, both of whom opposed surgery. Kiest saw claimant in February, 1984, at which time

[1] At the time of the injury, claimant was an undocumented alien worker.

there was still mottled and swollen skin. Kiest said that "sinus tarsi syndrome is a controversial, somewhat poorly defined syndrome of nerve compression * * * with uncertain results as a result of surgical procedure." Several months later, Weeks, in the same clinic as Smith, found the physical conditions unchanged but recommended against the surgery, although he had no operating experience with treatment of sinus tarsi syndrome. Dr. Eisler, a neurologist, performed a nerve conduction study and concluded that claimant's pain was musculoskeletal in origin.

An injured worker may choose an attending physician, ORS 656.245(3), and is entitled to the medical services which are necessarily and reasonably incurred in the treatment of the compensable injury. *McGarry v. SAIF*, 24 Or App 883, 888, 547 P2d 654 (1976). The referee concluded that the operation was reasonable and necessary, but the Board did not agree. It was persuaded by Carpenter's report and by what it

considered to be the "well-reasoned opinions of three examining physicians" (apparently, Kiest, Weeks and Eisler), as opposed to the "wavering opinion" of Puziss.[2] On *de novo* review, we disagree.

Puziss' medical opinions regarding claimant have been consistent. He initially diagnosed sinus tarsi syndrome and recommended surgery which, in his opinion, would probably provide relief of claimant's symptoms. His follow-up evaluation in January, 1984, noted continued pain and inability of claimant to walk for more than five or six blocks or to run at all and reiterated his belief in the value of the surgery as "curative or mostly curative." His final report in March, 1984, states that his experience has been that the surgery results in relief and indicates that he had scheduled a date to perform the surgery on claimant.

The opinions of the other physicians do not convince us that the surgery was not reasonable and necessary. Kiest expressed doubt that an aluminum pipe falling on a foot would produce a "crush" injury, and yet he recognized that claimant had continued skin mottling and slight swelling. Furthermore, Kiest's opinion appears to be influenced by personal sociological opinions rather than medical opinion:

> "Of considerable importance in the overall evaluation is the fact that this man is an undocumented worker who likely will be deported as soon as his medical condition becomes stationary and additional treatment is not indicted.
>
> " * * * * *
>
> "In addition the fact that this is an undocumented worker who cannot afford to get completely well makes the secondary gain factor important and would reduce the chances of surgical success."

Kiest gave no basis for those statements.

Weeks also found that claimant's immigration status was "contributing to his complaints" but conceded that claimant still had moderate swelling and defused tenderness. Carpenter initially agreed with Puziss that the surgery possibly

[2] The Board's conclusion was also based in part on the belief that the referee found that claimant was not credible. However, the referee did not find that claimant was not credible. Rather, he stated that some of claimant's statement made him uncertain whether claimant was untruthful or had a poor memory.

should be performed but eventually changed his opinion and concluded that it should not.

Weeks, Kiest and Carpenter do not express personal familiarity with sinus tarsi syndrome surgery. Puziss had performed the surgery and had done so with success. The evidence is clear that a year after the injury, claimant continued to have swelling, pain, and decreased use of his right foot despite conservative medical treatment. Even though the surgery is not frequently performed, the prognosis for alleviation of claimant's ongoing medical problems shows that the surgery was necessary and reasonable.

Claimant argues that his claim was prematurely closed in May, 1984. We agree. Claimant had continued pain and swelling and the treatment proposed by Puziss was not palliative but was suggested for the purpose of improving claimant's foot problem. *See Schuening v. J.R. Simplot & Company*, 84 Or App 622, 735 P2d 1, *rev den* 303 Or 590 (1987). Claimant's condition was not medically stationary on the date of closure.[3]

Reversed and remanded with instructions to reinstate referee's order setting aside employer's partial denial of surgery and award of attorney fees and to rescind the May 15, 1984, determination order as prematurely closed.

[3] Our decision that the claim was prematurely closed renders moot claimant's assignment of error that the Board erred in not awarding permanent partial disability.

IN THE SUPREME COURT OF THE
STATE OF OREGON

In the Matter of the Compensation of
Thomas L. Runft, Claimant.

RUNFT,
Petitioner on Review,

v.

SAIF CORPORATION et al,
Respondents on Review.

(WCB 83-03962; CA A34302; SC S32994)

In Banc

On review from the Court of Appeals.*

Argued and submitted December 2, 1986.

Robert K. Udziela, Portland, argued the cause for petitioner on review. With him on the brief were Diana Craine, Jeffrey S. Mutnick and Pozzi, Wilson, Atchison, O'Leary & Conboy, Portland.

Darrell E. Bewley, Assistant Attorney General, Salem, argued the cause for respondents on review. With him on the brief were Dave Frohnmayer, Attorney General, and Virginia L. Linder, Solicitor General, Salem.

LENT, J.

The decisions of the Court of Appeals and of the Workers' Compensation Board are reversed. Remanded to the Workers' Compensation Board for entry of an order holding SAIF responsible for payment of any compensation to which claimant may be entitled.

---

* Judicial review of decision of Workers' Compensation Board. 78 Or App 356, 717 P2d 248 (1986).

LENT, J.

The issue is whether an employer whose working conditions were the major contributing cause of a claimant's asbestosis may avoid responsibility for payment of compensation by showing that working conditions at the claimant's later employment contributed to the claimant's disability, where the claimant has made no claim against the later employer, and the first employer has not sought to join the later employer in the administrative proceeding. We hold that the first employer may not avoid responsibility in those circumstances.

Because there is evidence to support them, we take the facts as found by the Court of Appeals. *Sahnow v. Fireman's Fund Ins. Co.*, 260 Or 564, 568, 491 P2d 997 (1971). In *Runft v. SAIF*, 78 Or App 356, 717 P2d 248 (1986), the court found that claimant worked from 1959 to 1966 for Specialized Service (SS), which was insured by SAIF, during which he was exposed to great clouds of asbestos dust in a small room without ventilation or respiratory protection. Later he worked for

four years at International Harvester (IH), where he was occasionally exposed to asbestos. Subsequent thereto he had other employment, in which there was no exposure to asbestos. There is no finding of fact as to the dates of the employments following that at SS.

In January 1983 claimant filed a claim with SAIF contending that he had "asbestos poisoning" resulting from his work at SS. On the claim form under date February 3, 1983, SAIF's employee noted that acceptance or denial of the claim was deferred and that it was to be treated as a nondisabling occupational disease claim. By letter to claimant dated March 21, 1983, SAIF denied the claim.

> "You have filed a claim for asbestosis, which you allege to be an occupational disease as the result of exposure to asbestos while in the employ of Specialized Service, Inc. Insufficient evidence exists to substantiate that you were, in fact, exposed to asbestos while in their employ, nor is there sufficient medical evidence to substantiate that you do, in fact, have any condition as the result of your alleged exposure while in the employ of Special Services, Inc. Additionally, information in file discloses that you have a long history of heavy cigarette smoking, which appears to be the major contributing factor to your current lung complaints. Therefore, we are unable to

> accept responsibility for your condition, and without waiving other questions of compensability, this formal denial is made."[1]

Claimant timely requested a hearing. At the outset of the hearing on October 4, 1983, the referee inquired of claimant's counsel what issues were involved. Counsel answered that the primary issue was compensability and the secondary issue was a claim for attorney fees and penalties for unreasonable denial of the claim. Claimant's counsel drew to the attention of the referee that

> "SAIF has made no effort consistent with the *Luhrs* case [*SAIF v. Luhrs,* 63 Or App 78, 663 P2d 418 (1983)] and other cases that they rely on repeatedly to bring in any other employers in this case. * * * So I'm not quite sure what the defense is, if any."

The referee then asked SAIF's counsel whether there were any cross issues, and he stated that there were none.

In his opening statement to the referee, however, SAIF's counsel said:

> "Well, the basis for the denial, as stated on the denial, is that we question the amount and degree of exposure at this

[1] We have serious doubts that the phrase, "without waiving other questions of compensability," in the last sentence of this letter of denial should have any efficacy in light of OAR 436-54-305(4), which apparently was then in effect and provided:

> "The notice of denial in compliance with OAR 436-83 shall:
>
> "(a) specify the factual and legal reasons for denial;
>
> "* * * * *."

OAR 436-83-120, also apparently then in effect, provided that "the notice of denial shall specify the factual and legal reasons for denial." *Former* ORS 656.262(6) provided:

> "If * * * [SAIF] * * * denies a claim for compensation, written notice of such denial, stating the reason for the denial * * * shall be given to the claimant. * * *"

It appears that the presently applicable rule is OAR 438-05-055, which provides:

> "In addition to the requirements of ORS 656.262 to 656.270, the notice of denial shall specify the factual and legal reasons for denial. * * *"

employer. We have here to testify a man who was there at the beginning of Mr. Runft's employment, who did the same type of work and who will controvert much of what the claimant will have to say and has said about the amount of exposure, the description of the shop, and the ventilation, and those sort of things. I think there's a good deal of disparity in what claimant has told many people and what, indeed, is true.

"Also, the Referee will note, in the history, that the claimant was exposed subsequent to this employment, too. I believe Dr. Lawyer will indicate that that exposure may well have been detrimental.

"* * * * *

"Dr. Lawyer will probably indicate that exposure subsequent to our employer may well have been the material contributing factor to the development of whatever condition the claimant has now.

"Those are the two bases for our denial. I think we have adequate and proper grounds for the denial, penalties should not attach, and the denial should be affirmed."

We construe SAIF's original denial of this claim to have been related to compensability only. In that original denial, SAIF relied on two factual assertions: (1) that claimant was not exposed to asbestos at SS and (2) that he did not have any condition resulting from alleged exposure while employed at SS. SAIF's counsel's opening statement raised for the first time a defense of want of responsibility, as distinguished from compensability.

The referee found that claimant's exposure to asbestos while employed at IH contributed significantly to his disease. The referee concluded:

"Procedurally, claimant argues that SAIF cannot rely upon the last injurious exposure rule defense because no other employers were joined as a party to this proceeding. In reviewing the situations in *Luhrs* [*SAIF v. Luhrs*, 63 Or App 78, 663 P2d 418 (1983)], *Gupton* [*SAIF v. Gupton*, 63 Or App 270, 663 P2d 1300 (1983)] and *Graham* [*Wesley E. Graham*, 35 Van Natta 1303 (1983)], neither of the parties joined or attempted to join subsequent employers. *I find the defendant can rely on the evidence and need not join subsequent employers as a condition precedent to raising the last injurious exposure rule.*" (Emphasis added.)

Claimant requested Board review. The Board affirmed the referee's holding that SAIF could avoid responsibility by resort to the last injurious exposure rule without joining IH.

"With regard to claimant's arguments concerning joinder, although the court in *Bracke* noted that procedures exist pursuant to OAR 436-54-332 where one employer could join another employer, *Bracke v. Baza'r, supra*, 293 Or at 250 n. 5,

we believe there are certain unresolved jurisdictional problems lurking in a procedure which allows one *employer* to join another employer in the absence of a claim having been filed against that employer. *E.g. Syphers v. K-W Logging Co.*, 51 Or App 769 (1981). Certainly, for whatever it is worth, it has been the longstanding policy of this agency that motions by one employer to join another employer in a pending hearing

proceeding are consistently denied if the claimant has never made a claim against the employer sought to be joined." (Emphasis in original.)

On request for judicial review, the Court of Appeals affirmed. The court found that both the employment at SS and that at IH contributed to the disability suffered by claimant. The court held that there was no authority that would have permitted SAIF to join IH (and/or its insurer) "when, as here, compensability, as well as responsibility, was at issue at the time when the claim was denied and at hearing. *See* ORS 656.307; OAR 436-54-332." (Footnote omitted.)

If the Court of Appeals meant to state that responsibility, as distinguished from compensability, was at issue at the time of denial, we believe the court was under a misapprehension. SAIF's denial of this claim made no mention of the possible responsibility of any other employer or of the last injurious exposure rule. The Court of Appeals was correct that both compensability and responsibility were at issue at the time of hearing.

I.

An occupational disease is considered an "injury" under Oregon's workers' compensation law. ORS 656.804. For a disease to be an occupational disease, it must be a disease that "arises out of and in the scope of the employment, and to which an employe is not ordinarily subjected or exposed other than during a period of regular actual employment therein." ORS 656.802(1)(a). Under this statute an occupational disease is a disease whose "major contributing cause" is work related. *See McGarrah v. SAIF*, 296 Or 145, 166, 675 P2d 159 (1983); *Dethlefs v. Hyster*, 295 Or 298, 308-10, 667 P2d 487 (1983).

If a claimant has worked for only one employer, the claimant's task is relatively straightforward: the claimant must show that working conditions at that employment were

the major contributing cause of the disease. If, however, a claimant has worked for more than one employer, the claimant must show not only that the disease's major contributing cause was work related, but also show which employer is responsible for payment of compensation. This additional requirement creates problems of proof and assignment of responsibility for compensation.

The problem of proof is at least twofold. First, many occupational diseases, including asbestosis, often develop several decades after first exposure to the disease-causing substance. Although it may be relatively simple to identify the employments at which the claimant was or could have been exposed, it will often be difficult or impossible to establish the nature and degree of the exposure. Similarly, although the relationship between a disease and exposure to a substance may be well established, it will often be difficult to state with sufficient medical probability the degree to which, if any, a particular exposure contributed to the development of the disease.

The problem of assigning responsibility is both practical and legal. The practical problem is that, even if it is medically possible to allocate responsibility for an occupational disease among several employers, the time and other resources

necessary to do so may make the allocation expensive and inefficient. The legal problem is that there is no provision in Oregon's workers' compensation law for the apportionment of responsibility for a single disease or injury among employers. *See Bracke v. Baza'r*, 293 Or 239, 247, 646 P2d 1330 (1982); *Inkley v. Forest Fiber Products Corp.*, 288 Or 337, 342, 605 P2d 1175 (1980). The problem of allocation has been left for judicial and administrative resolution.

This court's solution to both the proof and allocation problems has been the last injurious exposure rule, which we adopted in *Inkley*. Briefly stated, if a workers' compensation claimant has worked for more than one employer that could have contributed to the claimant's occupational disease, the last injurious exposure rule assigns full responsibility for payment of compensation for the disease to the last such employer for whom the claimant worked.[2] *See Boise Cascade*

Corp. v. Starbuck, 296 Or 238, 241, 675 P2d 1044 (1984); *Fossum v. SAIF*, 293 Or 252, 256 & n 1, 646 P2d 1337 (1982); *Bracke*, 293 Or at 244-46; *Inkley*, 288 Or at 344-45; *see also* 4 Larson, The Law of Workmen's Compensation § 95.24-.26 (1986). The rule is really two rules, a rule of proof and a rule of assignment of responsibility, each designed to address the problems noted above.

The rule of proof operates generally for the benefit of claimants. *Bracke*, 293 Or at 249. It relieves claimants of the burden of proving the degree to which, if any, exposure to disease-causing substances at a particular employer actually caused the disease. The claimant is required to prove only that the disease was caused by employment-related exposure; the claimant is not required to prove that exposure at a particular employer's workplace caused the disease. Whether employment at any one workplace was the actual cause of the disease is irrelevant under the rule. *See Fossum v. SAIF, supra*, 293 Or at 256.

As a rule of assignment of responsibility, the last injurious exposure rule assigns full responsibility to the last employer at which the claimant could have been exposed to the disease-causing substance. This is true no matter how brief or insignificant the possible exposure at the last such employer. *See* Larson, *supra*, § 95.26(a). For this reason, the rule can be extremely arbitrary in a particular case, but this arbitrariness is mitigated in the long run as responsibility is spread proportionately among employers by operation of the law of averages. *See Bracke v. Baza'r, supra*, 293 Or at 249-50.

The principal benefit of assigning responsibility to the last employer is economy. It is more economical arbitrarily to assign full responsibility to the last employer than to attempt to apportion accurately responsibility according to causation. In addition, by assigning responsibility to an employer who can be identified without a determination of causation, the claimant is better protected from the risk of filing claims against the wrong employer. The limitations period for filing occupational disease claims is only 180 days. ORS 656.807. Within that period a claimant will generally be

[2] The "last injurious exposure" rule also applies to injuries at successive employers, *e.g., Boise Cascade Corp. v. Starbuck*, 296 Or 238, 675 P2d 1044 (1984), and to cases in which an employer is successively insured by two or more carriers, *e.g., Inkley v. Forest Fiber Products Co.*, 288 Or 337, 605 P2d 1175 (1980).

able to identify dates of employment and exposure to the disease-causing substance but will frequently be unable to determine whether and to what extent a particular place of

employment caused the disease. *See Inkley v. Forest Fiber Products Corp., supra,* 288 Or at 343-44.

II.

Although the last injurious exposure rule was designed primarily for the benefit of claimants, employers have attempted to use the rule defensively. In cases in which the claimant has not filed a claim against the employer that would be responsible under the rule, and that employer has not otherwise been made a party, invocation of the rule will usually, as in this case, have the effect of defeating the claimant's right to compensation altogether because of the 180-day limit for filing claims. For this reason, we have held that an employer cannot use the rule of proof to defeat a claim where the claimant has established a right of compensation from the employer by proving actual causation. *See Boise Cascade Corp. v. Starbuck, supra,* 296 Or at 243-45; *cf. Bracke v. Baza'r, supra,* 293 Or at 250 & n 5.

Starbuck, although it involved an injury rather than an occupational disease, is a good illustration of an employer's inability to use the rule of proof defensively. In *Starbuck* the claimant had suffered a back injury while employed by the first employer. While working for the second employer, the claimant's back injury worsened. The working conditions at the second employer were of the type that could have caused the back injury, but the Court of Appeals found that work at the second employer had not in fact contributed to the injury. This court did not permit the employer to invoke the rule as a defense because the rule of proof is primarily intended to ease the burden of proof for claimants. If claimants choose to prove actual causation, and thereby do not rely on the rule of proof, employers should not be able to defeat the claim using a rule that would no longer serve any purpose but to defeat the claim.

This claimant did not rely upon the rule of proof. He established that his exposure to asbestos at Specialized Service was an actual cause of his asbestosis and also that that exposure was the "major contributing cause" of his disease. Although his subsequent employment was of a type that could have caused his disease, SAIF could not have used the last injurious exposure rule as a rule of proof to defeat this claim. As a rule of assignment, however, the rule is relevant to this

case. Claimant's evidence established, and the Court of Appeals found, that his subsequent employment "significantly" contributed to his disease, though to a lesser extent than that at SS.

As we noted above, the assignment of responsibility aspect of the last injurious exposure rule serves essentially two purposes: administrative efficiency and definiteness in the assignment of responsibility. Where a claimant has actually established the degree to which two or more employers have been responsible for causing the claimant's disease, there is no administrative economy to be gained by application of the

rule. Second, the need for definiteness in the assignment of responsibility is a need of claimants; claimants must know against whom they should file their claims. This is not a reason for the defensive use of the rule.

III.

In *Bracke* we said, "Procedures exist whereby any causal employer can join a later causal employer in order to protect its proportional interest. *See, e.g.,* Oregon Administrative Rule 436-54-322." *Bracke,* 293 Or at 250 n 5. In its decision in this case, the Board noted our statement but questioned it because the Board believed "there are certain unresolved jurisdictional problems lurking in a procedure which allows one *employer* [original emphasis] to join another employer in the absence of a claim having been filed against that employer." For that statement the Board cited *Syphers v. K-W Logging, Inc.,* 51 Or App 769, 627 P2d 24 (1981). In that case, the claimant filed a claim and simultaneously filed a request for hearing. The Court of Appeals did no more than to hold that his request for a hearing was premature because the employer had 60 days in which to accept or deny the claim. We do not believe that case to be in point.

In the case at bar, the Court of Appeals held that there was no authority to permit joinder by SAIF of IH, citing ORS 656.307 and OAR 436-54-332, which is the same rule that we cited in *Bracke* as giving such authority.

Both the Board and the Court of Appeals are correct in concluding that ORS 656.207 and OAR 436-54-332 do not directly speak to occupational diseases; however, ORS 656.804 provides that an occcupational disease is considered to be an

injury. We see no reason that OAR 436-54-332 should not apply to the situation where there are two or more employers and two or more exposures to occupational disease. OAR 436-54-332 provided:

"* * * * *

"(2) The Compliance Division shall, by order, designate who shall pay a claim, if the claim is otherwise compensable, where there is an issue regarding:

"* * * * *

"(c) responsibility between two or more employers or their insurers involving payment of compensation for two or more accidental injuries; * * *

"* * * * *

"(3) Insurers or self-insured employers with knowledge of a situation as defined in subsection (2) shall expedite the processing of the claim by immediate priority investigation to determine responsibility and whether the claim is otherwise a compensable injury claim.

"(4) When a situation as described in subsection (2) arises, the insurers or self-insured employers shall immediately notify any other affected insurers or self-insured employers of the situation. A copy of all medical reports or other pertinent material available relative to the injury shall be provided the other parties.

"(5) Such notice received from another insurer or self-insured employer shall be notice of a claim referred by the Director as provided by ORS 656.265(3)."

Although OAR 436-54-332(2)(c) speaks specifically only to two or more accidental injuries involving two or more employers, we cited it in *Bracke* as being applicable to occupational disease claims. There is nothing in the rule to cause us to believe that it was not intended also to apply to occupational disease claims.

That being so, under subsection (3), when SAIF became aware that its insured and another employer were involved with an occupational disease that could have resulted from exposure at either or both places of employment, SAIF was required to engage in "immediate priority investigation to determine responsibility" as well as compensability. Under subsection (4), SAIF was required immediately to notify any other affected employer, which would include IH. Under

subsection (5), such notice, if given, would be treated by the notified employer or insurer as a claim referred by the Director of the Workers' Compensation Department under ORS 656.265(3), which provides:

> "Notice [of an accident] shall be given to the employer * * *. If for any reason it is not possible to so notify the employer, notice may be given to the director and referred to the insurer or self-insured employer."

The rule has the effect of requiring the employer who has notice of the situation described in subsection (2)(c) to bring in the later employer by a procedure that is equivalent to a claim against that later employer. We conclude that there is indirect authority for joinder even after request for hearing by the claimant where it becomes apparent that the situation described in subsection (2)(c) obtains.[3]

From exhibit 26 it appears that Dr. Lawyer, to whom SAIF's counsel referred in his opening statement to the referee, had written a report under date May 25, 1983, that should have alerted SAIF to the issue of responsibility. At any rate, exhibit 26, a letter from Dr. Lawyer received by SAIF on August 24, 1983, certainly alerted SAIF to the fact that claimant did indeed have asbestosis, and if SAIF would shift responsibility, SAIF was required by the administrative rule to undertake "immediate priority investigation" and to involve the later employer. We hold that SAIF's failure to do so prevents SAIF from utilizing the last injurious exposure rule to avoid responsibility for payment of this compensable claim.

The decisions of the Court of Appeals and of the Board are reversed, and this matter is remanded to the Board for entry of an order holding SAIF responsible for payment of any compensation to which claimant may be entitled.

---

[3] In the portion of the Board decision quoted above at page 5, the Board stated that it had been the longstanding agency policy not to allow the motion of an employer to join another employer if the claimant has not made a claim against the other employer. The Board cites no rule or statute as the basis for the policy. Our reasoning from the administrative rule should put an end to the policy in circumstances such as those in this case.

IN THE SUPREME COURT OF THE
STATE OF OREGON

In the Matter of the Compensation of
Earl H. Norby, Claimant.

NORBY,
Petitioner on Review,

v.

SAIF CORPORATION et al,
Respondents on Review.

(WCB 84-06365; CA A36929; SC S33507)

In Banc

On Review from the Court of Appeals.*

Argued and submitted June 2, 1987.

David C. Force, Eugene, filed the petition and argued the cause for Petitioner on Review.

Darrell E. Bewley, Assistant Attorney General, argued the cause and filed a response for Respondents on Review. With him on the response were Dave Frohnmayer, Attorney General, and Virginia L. Linder, Solicitor General, Salem.

PER CURIAM

The decision of the Court of Appeals is reversed and the case is remanded to that court for *de novo* review of the degree or extent of claimant's permanent disability.

* Appeal from an order of the Worker's Compensation Board. 82 Or App 157, 728 P2d 55 (1986).

PER CURIAM

Claimant petitioned this court to review a decision of the Court of Appeals which affirmed an order of the Workers' Compensation Board denying his claim for permanent partial disability benefits beyond a stipulated award for a prior injury. The Workers Compensation Board made that decision on the facts, reversing a contrary decision of the referee, but the Court of Appeals rested its affirmance of the Board's order on its interpretation of a statute, ORS 656.222. *Norby v. SAIF*, 82 Or App 157, 728 P2d 55 (1986). Because it appears that the Court of Appeals may have misapplied ORS 656.222, we reverse its decision and remand the case to that court for judicial review without reference to the statute.

Claimant first injured his back in December 1981, returning to work after a few weeks. He reinjured his back in August 1982, and again returned to his regular work as a press-line operator in a rubber mill, although he continued to experience low back symptoms. After a third injury in November 1983, claimant's treating physician released him for modified work, but claimant was unable to perform it.

The present order followed and relates to claimant's third injury. The referee granted an award of 35 percent (112 degrees) of unscheduled permanent disability benefits based on claimant's loss of earning capacity, plus attorney fees and

$600 in moving expenses. SAIF sought review of that award on grounds that it was excessive and that claimant was not entitled to the moving expenses.

The Board's order recites:

> "While this November 1983 injury claim was in open status and claimant was undergoing treatment, the parties entered into a stipulation in connection with the August 1982 injury claim, whereby claimant was awarded 32° (10%) unscheduled disability for that injury to claimant's low back. This stipulation does not appear in the record as an exhibit but apparently was executed in April of 1984."

After reviewing the evidence, the order continued:

> "We are required to award permanent disability which is due to this November 1983 industrial injury. ORS 656.214(5). We are also required, however, in determining an appropriate award for this injury, to take into consideration claimant's

> previous injuries and 'his past receipt of money for such disabilities.' ORS 656.222. The Referee considered the latter statutory provision, although it is unclear exactly what effect he thought the stipulated award of 10% unscheduled disability should have in determining claimant's possible entitlement to an additional unscheduled award. A significant factor which he did take into account is the fact that after claimant's two prior injuries, he was able to continue his employment, but after his third injury he was medically advised to discontinue this line of work and, in fact, found it necessary to do so.
>
> "* * * * *
>
> "In this case claimant received no permanent disability in connection with the December 1981 back injury, and apparently none was awarded upon closure of the August 1982 claim. However, claimant eventually received the aforementioned 10% unscheduled award in connection with the August 1982 injury, but the stipulated award was made based upon facts and circumstances existing after claimant had already sustained his November 1983 reaggravation (i.e. facts and circumstances existing at the time of the stipulated award). This is a potentially complicating factor not present in any of the cases discussing proper application of ORS 656.222."

The Board concluded that "[c]onsidering the permanent impairment resulting from all three industrial injuries," claimant had demonstrated "no more than impairment of a very minimal degree," which entitled him to no unscheduled award beyond 10 percent (32 degrees). Because claimant had received such an award in the claim made after the 1982 injury, the Board concluded that he was not entitled to a further award. The Board also denied the moving expenses.

In the Court of Appeals, claimant relied on his "permanent loss of earning capacity due to the compensable injury." He faulted the Board for considering impairment of function and asked the court on *de novo* review to reinstate the referee's finding as to loss of earning capacity. SAIF Corporation's brief defended the Board's order on the evidentiary record.

The Court of Appeals, however, seems to have concluded that an award following the third injury was barred by ORS 656.222. This section provides:

> "Should a further accident occur to a worker who is receiving compensation for a temporary disability, or who has been

> paid or awarded compensation for a permanent disability, the award of compensation for such further accident shall be made with regard to the combined effect of the injuries of the worker and past receipt of money for such disabilities."

The court believed that the section applied because the stipulated award of 10 percent unscheduled disability mentioned in the order had been made before closure of claimant's claim for the 1983 (third) injury.

Before this court, both claimant and SAIF Corporation agree that ORS 656.222 does not apply to this case. In answer to questions submitted by this court, SAIF Corporation observes that from the inception of the Workers' Compensation Act this section had been directed at double payments, not at successive determinations of disability. *See* Or Laws 1913, ch 112, §§ 21(f) & 21(h); *Green v. State Ind. Acc. Com.*, 197 Or 160, 251 P2d 437 (1952).

We agree that ORS 656.222 does not prohibit a determination of the extent of claimant's permanent disability after the last injury merely because a 10 percent permanent disability was established in consequence of the second claim. The statute only prescribes that any payments made or compensation for permanent disability awarded shall be counted in an award for a later accident.

After quoting the command of ORS 656.222 to take into account "the combined effect of the injuries" and the "past receipt of money for such disabilities," the Court of Appeals stated that

> "[t]he Board made its determination in that manner and concluded that the combined effect of claimant's injuries was a minimal impairment of earning capacity, for which he was entitled to an award of 10 percent unscheduled disability."

82 Or App at 160. There is no indication in the opinion whether the court reviewed this determination *de novo* and agreed with it; rather, the opinion implies that the court affirmed the Board as a matter of law under ORS 656.222. Perhaps we and the parties only misunderstand the opinion. But because that view of the law would be erroneous, we reverse the decision of the Court of Appeals and remand the case to that court for *de novo* review of the degree or extent of claimant's permanent disability.

IN THE SUPREME COURT OF THE STATE OF OREGON

KNAPP,
Respondent on Review,
v.
CITY OF NORTH BEND,
Petitioner on Review.

(TC 85-919; CA A38486; SC S33737, S33823)

In Banc

On review from the Court of Appeals.*

Argued and submitted on July 7, 1987.

Daniel M. Spencer, Coos Bay, argued the cause and filed the petition on behalf of the petitioner on review. With him on the petition were Paul L. Roess and Foss, Whitty & Roess, Coos Bay.

Michael D. Reynolds, Assistant Attorney General, Salem, argued the cause on behalf of the intervenor/petitioner on review, State of Oregon Bureau of Labor and Industries. The petition for review was filed by Dave Frohnmayer, Attorney General, Virginia L. Linder, Solicitor General, and David Schuman, Assistant Attorney General, Salem.

Michael R. Stebbins, North Bend, argued the cause on behalf of the respondent on review.

Susan P. Graber, Eileen Drake and Stoel, Rives, Boley, Fraser & Wyse, Portland, filed an *amici curiae* brief on behalf of 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.

Larry K. Amburgey, Craig A. Crispin and Bullard, Korshoj, Smith & Jernstedt, P.C., Portland, filed an *amici curiae* brief on behalf of City of Portland; Food Employers, Inc.;

HealthLink; Lamb-Weston, Inc.; Lynden Farms/Belozer's Hatchery; McCracken Motor Freight, Inc.; McPike Marketing, Inc.; Mid-Columbia Medical Center; Nike, Inc.; Northwest Packers Industrial Association, Inc.; Oregon Self-Insurers Association; Oregon Trucking Association, Inc.; Pacific Northwest Bell; PayLess Drug Stores Northwest, Inc.; Portland Chamber of Commerce; The Port of Portland; Rogue Valley Medical Center; Silver Eagle Industries; Stayton Canning Company; Tektronix, Inc.; Timber Operators Council; Truitt Brothers, Inc.; United Grocers, Inc.; and Western Bank.

GILLETTE, J.

The decisions of the Court of Appeals and the trial court are reversed.

* On appeal from Circuit Court, Coos County, Honorable Richard L. Barron, Judge. 83 Or App 350, 732 P2d 31 (1987).

GILLETTE, J.

The issue in this employment discrimination case is whether an employer must reinstate a worker, who has sustained a compensable injury, to his or her former position, upon the worker's demand for reinstatement, when the position the worker formerly occupied still exists but no longer is vacant. ORS 659.415 provides:

> "(1) 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.
>
> "(2) * * * * *
>
> "(3) Any violation of this section is an unlawful employment practice."

The Court of Appeals held that a former position is "available" within the meaning of ORS 659.415(1) if it still exists, even if, at the time of the demand for reinstatement, it has been filled by a permanent employe. *Knapp v. City of North Bend*, 83 Or App 350, 732 P2d 31 (1987). We hold that the legislature intended to require reinstatement to a former position only where that position is existing and vacant. Accordingly, we reverse.

From October 8, 1975, to January 22, 1983, plaintiff worked as a sergeant on the North Bend police force. On January 22, 1983, he sustained a compensable injury and, as a result, was unable to work until November 27, 1984. Upon being released to work on that date, plaintiff demanded reinstatement to his former position pursuant to ORS 659.415(1). Defendant city refused, because another employe had been promoted permanently to fill plaintiff's former position and because there were no other suitable vacant positions at that time. On May 29, 1985, a patrol officer position became vacant, and defendant reinstated plaintiff in that position.

Plaintiff filed this action, alleging that defendant

engaged in an unlawful employment practice in refusing to reinstate him to his former position. The case was tried on stipulated facts. The trial court ruled that defendant was required to reinstate plaintiff in his former position. The court ordered that plaintiff be reinstated and awarded him back wages from the time of his request for reinstatement.

The Court of Appeals affirmed. It found that the proviso that a former position be "available" was ambiguous and that the legislative history offered little guidance in determining whether "available" meant "existing and vacant" or, merely, "existing." 83 Or App at 355. The court then examined which definition was more consistent with the legislature's policy in enacting ORS 656.415(1). Defendant had argued that the legislature intended to preserve the employ-

ment relationship while permitting the employer to maintain an orderly workplace by filling vacancies with permanent employes, rather than temporary replacements for injured workers who may be unable to return to work for long periods of time.[1] Plaintiff had argued that the legislature's primary purpose was to facilitate an injured worker's return to self-sufficient status. The trial court found that, although both arguments had merit, plaintiff's interpretation of the term "available" was the more reasonable, because:

> "The Oregon legislature could not have intended for an injured workman to be jobless because his employer must fill the workman's position during his period of disability. This would put a high premium on seeking benefits, especially in cases where a workman has no choice because his injury is of such a severity that he could not work even if he wanted to do so. The workman could do nothing to protect himself. On the other hand, the employer can protect itself by making it clear that any replacement may very well be temporary. This may not be the best solution, but at least it is available to the employer."

The Court of Appeals agreed, noting that "[u]nder the current statute, as under the earlier version construed by the court in *Shaw*, the interpretation defendant advocates 'would permit an employer unilaterally to vitiate the mandate

of ORS 659.415 and to thwart the broader legislative scheme to afford employment opportunity and security to the handicapped.' " 83 Or App at 357 (quoting *Shaw v. Doyle Milling Co.*, 297 Or 251, 255, 683 P2d 82 (1984)).

In *Shaw*, this court held that, under a previous version of ORS 659.415(1),[2] an employer was required to reinstate a worker to the worker's former position even though that position had been filled by another permanent employe. In 1981, three years before *Shaw* was decided (but after the events with which *Shaw* dealt), the legislature amended ORS 659.415(1) to add, *inter alia*, the proviso that the former position be "available." Or Laws 1981, ch 874, § 14. Some of the legislative history of the amendment suggests that the legislature intended to clarify, not to change, the law. Plaintiff argues that, therefore, the legislature must have intended the *Shaw* rule, which was announced three years after the amendment, to apply to the amended version.

The Court of Appeals correctly concluded that *Shaw* is not dispositive. That case interpreted the pre-1981 version of ORS 659.415(1) three years after 1981, when the language at issue here was added to the statute. We turn to an examination of the language added in 1981.

---

[1] As defendant points out, it may be difficult to find qualified workers who are willing to accept temporary employment. Moreover, if ORS 659.415 means "existing, even if not vacant," there is no limit on how long an employer would be required to hold the worker's former position open.

[2] Prior to 1981, ORS 659.415 provided:

> "(1) A worker who has sustained a compensable injury shall be reinstated by the worker's employer to the worker's former position of employment or employment which is available and suitable upon demand for such reinstatement, provided that the worker is not disabled from performing the duties of such position. 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.
>
> "(2) Any violation of this section is an unlawful employment practice."

We agree with the trial court that the policy arguments submitted on behalf of both employers and injured workers have merit. The statute under consideration here clearly was the result of the legislature's balancing of those competing interests, intending to achieve some sort of compromise by adding the word "available." The Court of Appeals went through the balancing of the competing policy considerations for itself in arriving at what it believed to be the most "reasonable" interpretation of the term "available." We decline to embark upon such an analysis because there are

other indications of the legislature's intent sufficient to demonstrate that "available" means "vacant."

The Bureau of Labor and Industries (Bureau) is charged with the administration of the employment discrimination law. ORS 659.040 to 659.103. Effective January 26, 1983, the Bureau promulgated OAR 839-06-140, which defines "available," for the purposes of ORS 659.415(1), as follows:

> "(1) Except as limited by sections (2) and (3) of this rule, a job is available if it is:
>
> "(a) Vacant at the time of the injured worker's demand or becomes vacant after the injured worker's demand for reinstatement/reemployment; or
>
> "(b) Filled but available under a provision of the employer's policy and practices or a provision of a valid collective bargaining agreement.
>
> "(2) A job is not available if another worker has a prior right to that job:
>
> "(a) Under a provision of a valid collective bargaining agreement; or
>
> "(b) Under an employer's recall from layoff system which identifies a method for determining layoff and recall rights and places workers on a list in a specific order.
>
> "(3) The employer has no duty to create a job for the returning injured worker."

The Court of Appeals noted that, in 1981, a Bureau representative told the House Committee on Labor that the 1981 amendment was intended to clarify the statute's language, not to change it. The court concluded that the agency's interpretation of the term "available" was unhelpful, because:

> "[OAR 839-06-140] simply perpetuated the Bureau's incorrect understanding of what the unamended statute meant and, therefore, what the Bureau regarded the clarifying 1981 amendment as continuing to mean." 83 Or App at 354 n 3.

The summary dismissal of the administrative rule quoted above by the Court of Appeals was inappropriate. Even if the Bureau's understanding of the pre-1981 language was incorrect, the administrative rule was promulgated under the *post*-1981 amended version of ORS 659.415. For its part, the *Shaw* decision, issued the year after OAR 839-06-140, did not

purport to construe the word "available" nor, as noted above, is it dispositive of the statute's meaning after the 1981 amendment. The Court of Appeals erred in finding that *Shaw* had, in effect, invalidated the rule.

The interpretation of a statute by the agency charged with its enforcement and administration, although not binding, is entitled to our careful consideration. *Van Ripper v. Liquor Cont. Com.*, 228 Or 581, 593, 365 P2d 109 (1961). It is true that "available" is not a highly technical term requiring a high degree of deference to the agency's expertise. *Cf. McPherson v. Employment Division*, 285 Or 541, 591 P2d 1381 (1979). Neither is it a "delegative" term requiring the agency to complete a partially-stated legislative policy. *See Springfield Education Assn. v. School Dist.*, 290 Or 217, 228-30, 621 P2d 547 (1980). On the other hand, the legislature has met three times since the rule was promulgated without amending the statute. *See Spencer v. City of Portland*, 114 Or 381, 235 P 279 (1925) (practical interpretation of a statute by the agency charged with its administration, if acted on for a number of years, will not be disturbed except for very cogent reasons).

In addition, the Bureau's interpretation of "available" is persuasive for reasons apparent on the face of the statute itself. The word "available" appears three times in the current version of ORS 659.415(1), and once in a companion statute, ORS 659.420.[3] Absent any indication to the contrary, we assume that statutory terms have the same meaning throughout a statute. *Pense v. McCall*, 243 Or 383, 389, 413 P2d 722 (1966). ORS 659.415 provides that, if the injured worker's former position is not available, the worker must be reinstated to another position that is suitable and — again — available. In this context, we think it highly unlikely that the legislature intended to give a previously injured worker the absolute right to displace another employe who holds a "suitable" job, even if that job was not the injured worker's former position. The Court of Appeals' interpretation either would attribute to the legislature such an intent or it would give

different meanings to the same term, depending on where that term is placed in the statute. Neither result is supportable.[4]

We conclude that, by adding the word "available" to ORS 659.415(1) in 1981, the legislature intended to require reinstatement to a former position only if the former position still exists and is vacant. Because the position at issue here had been filled by a permanent employe when plaintiff demanded reinstatement, defendant did not commit an unlawful employment practice in failing to reinstate plaintiff to that position. For that reason, the award of back wages also was improper.

The decisions of the Court of Appeals and the trial court are reversed.

---

[3] ORS 659.420(1) provides:

"A worker who has sustained a compensable injury and is disabled from performing the duties of the worker's former regular employment shall, upon demand, be reemployed by the worker's employer at employment which is available and suitable."

[4] It is also significant that, at the time that the legislature adopted the availability requirement for reinstatement to a former position under ORS 659.415, the Court of Appeals had interpreted the word "available," as it was used a companion provision, to mean "vacant." *Carney v. Guard Publishing Co.*, 48 Or App 147, 616 P2d 548, *modified* 48 Or App 927, 630 P2d 867, *rev den* 290 Or 171 (1980) (interpreting ORS 659.420(1)).

INDEX CONTENTS

OVERVIEW OF SUBJECT INDEX

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

CITATIONS TO COURT CASES 1987

CITATIONS TO COURT CASES 1987

CITATIONS TO COURT CASES 1987

CITATIONS TO COURT CASES 1987

COURT CASE----------PAGE(S)

REFERENCES TO CASES IN VAN NATTA'S 1987

CASE NAME----------PAGE(S)

REFERENCES TO CASES IN VAN NATTA'S 1987

CASE NAME----------PAGE(S)

REFERENCES TO CASES IN VAN NATTA'S 1987

CASE NAME----------PAGE(S)

REFERENCES TO CASES IN VAN NATTA'S 1987

CITATIONS TO OREGON REVISED STATUTES

ADMINISTRATIVE RULE CITATIONS

Administrative Rule---------Page(s)

LARSON CITATIONS

OREGON EVIDENCE CODE CITATIONS

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 1987

Name, WCB Number (Month/Year)

Abrahamson, Hatsuyo, 86-02105 (9/87)
Adams, James G., 86-08747 etc. (5,6/87)
Adkins, Sylvia E., 86-00999 (7/87)
Akers, Earble G., 85-12627 (9/87)
Akin, James N., 86-04468 (7/87)
Albert, Joseph S., 83-06649 (9/87)
Alcorn, Arthur E., 85-03809 (5/87)
Alertas, Barry W., 85-14966 etc. (9/87)
Allen, Rose A., 86-08593 etc. (9/87)
Amell, James M., 86-09947 (9/87)
Amstad, Adolph J., 86-01032 (5/87)
Anderson, Bonnie L., 86-03003 (9/87)
Anderson, Howard L., 85-03387 (4/87)
Andrews, Stephen L., 86-00238 (9/87)
Armstrong, Frank C., 86-08508 (9/87)
Atkinson, Jeffrey B., 85-11573 (6/87)
Aubrey, Mary B., 85-01809 (9/87)
Audette, David L., 86-00906 etc. (7/87)
Augsburger, Reginald, 86-08048 (9/87)
Baker, Richard C., 85-03227 (6/87)
Baney, Ruby L., 86-17071 (9/87)
Barnes, Douglas R., 85-02451 (8/87)
Barney, Charles D., 86-00377 (4,5/87)
Barnhart, Larry D., 86-06199 (8/87)
Barrett, Laura K., 85-05064 etc. (6/87)
Barry, Merle R., 86-03398 (3/87)
Bartell, David L., 84-04211 (9/87)
Beaudoin, Roland, 85-10858 etc. (3/87)
Beeman, Rudolph A., 86-08337 (6/87)
Beemer, Richard L., 86-03537 (5,6/87)
Bell, Rita K., 86-09621 (9/87)
Bemer, Leona A., 85-09157 (7/87)
Bentley, Alfred D., 86-05770 (6/87)
Berdot, Thomas J., 85-07225 (7/87)
Bethell, Carl S., 85-14234 etc. (9/87)
Bettin, Clifford A., 85-12594 (3/87)
Billings, Christeen E., 85-05273 (9/87)
Billings, Fredrick I., 85-09674 (3/87)
Bilyeu, Virginia K., 85-14842 etc. (5/87)
Bingaman, Max F., 86-05449 (9/87)
Blacklaw, Ronald L., 86-01156 (2/87)
Bland, Richard L., 85-08529 (6/87)
Blazer, Janet R., 86-05942 (9/87)
Blevins, Donald F., 85-13517 (9/87)
Blount, Joel D., 85-11919 (3/87)
Blum, Steven D., 85-00133 etc. (2/87)
Bodunov, Uliana, 86-04401 (8/87)
Bogle, James E., 85-12706 (3/87)
Boice, Court & D. Dawn, 85-14779 (3/87)
Bolds, Isaac, Sr., 86-07092 (5/87)
Bolton, Norma J., 86-03073 (7/87)
Bond, Beverly A., 85-10060 (6/87)
Bonner, Betty R., 85-10732 (6/87)
Bonneville, Ivan, 86-01898 (8/87)
Borde (employers), 85-12441 (5/87)
Borter, Larry D., 85-11362 etc. (3/87)
Bostock, Velora M., 84-04612 (6/87)
Bothum, Janice J., 86-10323 (9/87)
Boyle, Richard A., 85-15071 (6/87)
Braley, Horace W., 86-00645 (3/87)
Bratton, Reggie L., 86-07490 etc. (9/87)
Brenner, John R., 85-07631 (7/87)
Britt, Shirley A., 86-05940 (9/87)
Brooks, Mina L., 85-14818 (6/87)
Brosig, Stephanie L., 85-13525 (5/87)
Brown, Ben L., 86-04740 (5/87)
Bruno, Michael J., 85-09634 (1/87)
Buehling, Virginia H., 85-08712 (4/87)
Buie, Bill W., 85-16106 (8/87)
Burck, Larry A., 86-01358 (9/87)
Burleigh, Stephen A., 85-10062 (3/87)
Burnett, Jerry, 86-09919 (9/87)
Burns, Anthony D., 85-09900 etc. (4/87)
Burrows, William B., 86-08596 (7/87)
Burt, Nadine J., 85-09101 (9/87)
Bushman, Luke F., 84-01817 (4/87)
Busse, Joanne M., 86-06275 etc. (8/87)
Campbell, Herbert L., 85-12482 (3/87)
Campbell, Howard E., 83-12155 (5/87)
Campbell, Mary A., 86-03885 (9/87)
Canell, Alvin H., 86-00826 (7/87)
Carlon, Elma J., 86-07610 (6/87)
Carroll, John T., 85-10292 (3/87)
Cartwright, Julie P., 85-13530 (7/87)
Catron, Woodrow, 85-07900 etc. (7/87)
Chandler, Ronald C., 85-06459 (9/87)
Chase, Mary K., 85-00384 (3/87)
Chesley, Twila N., 84-04906 (7/87)
Clark, Jeannie, 85-10576 (3/87)
Cogburn, Ola B., 86-01502 etc. (6/87)
Cole, Richard W., 86-00590 (4/87)
Colvin, Allan B., 86-05915 (9/87)
Comstock, Virgil K., 85-06959 etc. (7/87)
Connell, Lisa M., 86-10414 (9/87)
Cookston, John H., 86-04478 (9/87)
Coolbaugh, George D., 85-12929 (4/87)
Cordell, Dell R., 86-12237 (9/87)
Cordrey, Gayle D., 85-09713 (5/87)
Cortez, Jesus E., 84-08413 (4/87)
Cosler, Robert G., 85-04916 (4/87)
Couch, Edwin L., 86-02784 etc. (6/87)
Crabtree, Josh, 82-09086 (6/87)
Craft, Billy L., 86-08136 (9/87)
Craig, Joan L., 86-04844 (5/87)
Crawford, Dee M., 86-02855 (7/87)

Name, WCB Number (Month/Year)

Crickette, Ada L., 86-05407 (6/87)
Cross, Linfield, 86-01317 (8/87)
Crow, Lanny M., 85-07146 (1/87)
Crumley, Edward T., 85-12902 (6/87)
Cudaback, Susan K., 85-04127 (6/87)
Cude, David L., 85-09746 (4/87)
Cummings, William F., 86-01859 etc. (4/87)
Cundiff, James M., 86-12598 (9/87)
Cundiff, Martin D., 85-13989 (4/87)
Daniels, Wilbur R., 85-01675 (6/87)
Danielson, Paul E., 86-09787 etc. (8,8/87)
Davenport, Warren E., 85-09061 (3/87)
Davidson, Richard, 85-08601 (9/87)
Davis, Betty Lou, 85-11132 etc. (4/87)
Davis, William D., 86-06476 (6/87)
Dawkins, Roland L., 85-11265 (4/87)
Deadmond, Gerald R., 84-03093 etc. (9/87)
Decker, Thomas V., 86-05681 (4/87)
Defilippis, Wayne C., 85-09603 (3/87)
Degraff, Clara J., 86-00138 (6/87)
Deleone, Samuel A., 86-01008 etc. (9/87)
DeLong, Elizabeth A., 85-14331 (8/87)
Dick, Alvin L., 85-13494 (8/87)
Dickerson, Loren E., 86-05637 (6/87)
Dickey, Ronald H., 85-15912 (7/87)
Dillard, LaDonna D., 85-11680 (4/87)
Dobbelaere, Melvin, 85-02648 (9/87)
Dobson, Walter E., 85-05639 (8,9/87)
Donaldson, Kenneth L., 86-07957 (9/87)
Doran, Dean T., 85-12793 (4/87)
Downey, Mary A., 86-00455 (9/87)
Drews, Walter F. II, 85-12763 (3/87)
Dunsmoor, James E., 86-10156 (7/87)
Dvorak, Douglas K., 85-10491 etc. (4/87)
Edwards, Bruce A., 85-06819 (8/87)
Edwards, William G., 86-03077 (9/87)
Elliott, Jacqueline A., 85-09744 (9/87)
Elliott, Jubal, 85-12973 etc. (5/87)
Emele, Della L. (Hansen), 86-03119 (9/87)
Endicott, Robert W., 85-05131 (4/87)
Endsley, Gerald, 85-13448 (5/87)
Engen, Sharon C., 85-15192 etc. (6/87)
Eriksen, Carl L., 85-11112 (9/87)
Essy, Frank M., 86-00467 (9/87)
Estes, Pamela R., 85-12058 (9/87)
Fair, Charles E., 85-11761 (3/87)
Faulkner, Patricia L., 85-16062 etc.(9/87)
Fenn, Gladys M., 85-04594 (9/87)
Ferguson, Larry W., 86-09703 (9/87)
Finsand, Robert J., 85-07130 (9/87)
Fly, Dorothy M., 84-11957 (3/87)
Fonseca, Richard S., 86-04434 (9/87)
Foss, Chad A., 85-11598 (3/87)
Fox, Marie H., 86-04025 (8/87)
Frisbie, Barbara L., 85-14411 (4/87)
Funke, Tim W., 86-02307 (6/87)

Name, WCB Number (Month/Year)

Galar Enterprises, 85-12441 (5/87)
Gallagher, Ruth F., 85-12992 (6/87)
Galster, David L., 85-06949 (5/87)
Gatens, Lester W., 84-04437 (5,5,7,8/87)
Geller, Tina A., 86-04542 (7/87)
George, Dorla R., 86-00360 (7/87)
George, Lloyd E., 85-09083 (4/87)
Gibson, Michael L., 85-15518 (5/87)
Gibson, Virginia B., 84-11221 (9/87)
Gifford, George, Sr., 86-11922 (9/87)
Gill, William R., 86-03372 (1/87)
Glover, Stanley A., 85-14020 etc. (4/87)
Goodell, Gloria E., 85-14683 (5/87)
Gordon, Sam A., 84-13335 (9/87)
Gould, Carolyn N., 84-13578 (3/87)
Granville, Alton R., 86-02923 (8/87)
Grasley, Ronald J., 85-06360 (4/87)
Graves, Billy R., 85-13472 (7/87)
Greenstreet, Walter M., 85-08618 (9/87)
Gregg, Dolores R., 85-08251 (4/87)
Gregg, Lucille A., 86-09263 etc. (9/87)
Griffin, Jean, 86-03647 etc. (9/87)
Guidoni, Joseph M., 86-08261 (6/87)
Haakinson, Linda L., 85-15126 (8/87)
Hafdahl, Walter A., 86-05586 (7/87)
Hamilton, Richard R., 85-06136 (6/87)
Hanley, Gordon, 86-11918 (8/87)
Hardy, Michael, 84-04180 (5/87)
Harlan, Ray J., 85-15200 etc. (4/87)
Harms, David A., 85-14957 (7/87)
Hart, Sharon K., 85-14884 etc. (9/87)
Hartman, Greg, 86-10525 (8,9/87)
Hatfield, Steve D., 86-07555 (8/87)
Hawes, Richard A., 85-15798 (4/87)
Hawk, Gary L., 86-01097 etc. (9/87)
Hayes, Thomas G., 86-02338 (9/87)
Heartt, Luveta S., 85-10674 (5/87)
Hebert, Opal M., 85-14806 (9/87)
Hegge, Randy S., 85-12779 (6/87)
Helzer, Steven G., 84-12732 (8/87)
Henderson, Claude E., 84-00464 (5/87)
Henderson, Shelby F., 85-14573 etc. (6/87)
Hendreson, Audrey, 84-00537 (5/87)
Hernandez, Alberto C., 85-07238 (3/87)
Herrera, Nelly C., 86-11085 (8/87)
Herring, Duane R., 86-04577 (9/87)
Heusser, Glade R., 85-12199 (5/87)
Hicks, Jacky C., 86-01847 (9/87)
Hilderbrand, James R., 85-15943 (8,9/87)
Hill, Buford (Bud) R., 86-00857 (6/87)
Hill, Dallas E., 85-03483 etc. (4/87)
Hill, Richard A., 85-02167 (3/87)
Hitt, Marion M., 85-11270 (1/87)
Hodge, Wesley D., 85-09350 (6/87)
Honeywell, Theressa A.,84-10571 etc.(3/87)
Hood, E. Edward/Mary M. (7/87)

Name, WCB Number (Month/Year)

Hooten, Ruby D., 86-12052 (9/87)
Howard, Gerald C., 85-00560 (2/87)
Hubbard, Treva K., 85-09607 (1/87)
Hunter, Ronald F., 86-09355 (7/87)
Hutton, Glen T., 85-12744 (5/87)
Hyde, James R., 85-13509 (5/87)
Hyser, Buddy W., 86-03895 (6/87)
Ingram, James C., 86-11024 (7/87)
Ivory, Marshall, 85-06896 (9/87)
Jacob, Patrick I., 86-13846 (8/87)
James, Gregory E., 86-02941 (6/87)
Januik, Bonnie Lyn M., 85-12411 (6/87)
Jaques, Dean C., 85-05270 (3/87)
Jaques, Robert C., 86-15437 (9/87)
Jeffers, Vickie L., 86-02232 (6/87)
Jenkins, Phyllis L., 86-02010 (7/87)
Jensen, Junius P., 86-03147 (8/87)
Johnson, James S., 85-13375 (6/87)
Johnson, Julie E., 85-08574 (6/87)
Johnson, Sharon M., 85-11452 (6/87)
Johnson, Violet R., 84-03741 (5/87)
Johnson, William P., 85-12441 (5/87)
Johnstone, Troy A., 86-03586 (6/87)
Jones, Norma, 85-03474 (5/87)
Jordan, Donald L., 85-09429 (5/87)
Justus, John L., 85-14054 (4/87)
Kaeb, John C., 85-15939 (9/87)
Kane, Robert J., 86-01495 (5/87)
Karpurk, Dennis R., 85-07027 (3/87)
Karther, Richard, 85-06543 (3/87)
Kauble, Junita J., 84-07892 (9/87)
Kauffman, John R., 86-09450 (7/87)
Keifer, Cynthia, 85-11366 (3/87)
Keller, Anatoli A., 87-06943 (5/87)
Kemp, Latreshia M., 85-12522 (7/87)
Kent, Hazel C., 85-10421 etc. (4/87)
King, Willie, 85-09246 (7,8,9/87)
Kirk, Kenneth J., 85-05440 (7/87)
Knapp, Carol J., 86-02762 (7,7/87)
Koerschgen, Linda F., 85-08211 etc. (8/87)
Kordon, Emil, 86-01089 (6/87)
Kosharek, Bruce W., 85-07367 etc. (9/87)
Kraft, Paul, 86-00913 (5/87)
Kuper, Clarence P., 84-12510 (9/87)
Lambert, Dennis I., 85-15094 (8/87)
Land, Rose, 85-03952 (4/87)
Lariccia, Chris L., 86-08144 (8/87)
Larson, Deborah K., 85-11726 (3/87)
Laurence, Cathie M., 86-05247 (9/87)
Lavender, Herbert W., 86-00144 (3/87)
Lawrocki, Susanne D., 85-13789 (5/87)
Lawson, David B., 84-10908 (6/87)
Layman, Paulette, employer (3/31)
LeClair, James R., 85-12460 (6/87)
Lee International Trading (Employer)(9/87)
Leland, Layton B., 86-00681 (4/87)

Name, WCB Number (Month/Year)

Lemons, Dennis F., 85-07404 (5/87)
Lentz, Gordon L., 85-12770 etc. (8/87)
Lewis, Robert E., 85-10798 (4/87)
Lingo, William J., 86-14664 (9/87)
Little, Sharon D., 86-08298 (8/87)
Littleton, Robert S., 85-04258 (6/87)
Logan, Robert W., 86-11986 (9/87)
Lonewolf, Norma J., 85-09956 (9/87)
Longanecker, Wayne L., 85-04374 etc.(9/87)
Lucas, Edward D., 85-08631 (8/87)
Lund, Kathryn E., 84-13179 etc. (4/87)
Lundeen, Robert E., 86-00008 (7/87)
MacFawn, Coburn I., 85-09837 (4/87)
Mageske, Annette K., 84-13399 (5/87)
Maine, Keith M., 85-15171 (4/87)
Makinson, Joseph P., 86-03697 (8/87)
Malm, Naomi, 86-02976 (7/87)
Marino, James J., 86-01686 etc. (4/87)
Mark, Denton C., 85-14280 etc. (4/87)
Martin, Judy M., 85-15894 (4/87)
Martinez, Rafael, 85-09878 (9/87)
Mauch, Jean, 84-03133 (5/87)
Maurer, Lauren D., 85-07106 (4/87)
McArtor, Timothy L., 86-07763 (5/87)
McCabe, Donald L., 85-10738 etc. (2/87)
McCalley, Diana L., 86-09180 (8/87)
McCulloch, James D., 85-12896 (8/87)
McDaniel, Clifford G., 85-10966 (7/87)
McJunkin, Eldon L., 84-10791 (3/87)
McKenzie, James L., 84-05784 (5/87)
McMullen, Chris S., 86-09673 (9/87)
Meacham, Helen E., 85-01674 (9/87)
Meadows, Steve C., 86-13242 (9/87)
Mellin, Don B., 86-06467 (6/87)
Mendes, Michael, 86-08526 (9/87)
Mestdagh, Oscar, 85-04348 (7/87)
Meyer, Stephen G., 86-09087 (7/87)
Michael, Mary A., 85-05630 (8/87)
Mills, Robert V., 85-14889 (7/87)
Mills, Rose, 85-02721 (9/87)
Miner, Henry C., 86-03195 (6/87)
Mitchell, Karl E., 86-01597 etc. (6/87)
Moberly, Eric A., 86-03127 (7/87)
Mock, Wallace W., 85-14684 (6/87)
Mohr, Kari S., 86-02479 (8/87)
Monroe, Judith (Cayanus), 84-07513 (9/87)
Montgomery, Robert, 85-10101 etc. (2,3/87)
Moore, Richard A., 86-00561 (4/87)
Moore, Robert L., 85-12011 (3/87)
Moore, William H., 86-04063 (4/87)
Moore, William H., 86-08734 (7/87)
Morford, Larry M., 84-00145 etc. (9/87)
Morgan, Paul A., 86-04699 (7,8,8/87)
Morilon, Lowell K., 86-04394 (4/87)
Morrow, William R., 85-08587 (3/87)
Morse, Earl E., 85-14823 (5/87)

Name, WCB Number (Month/Year)

Morton, Claude A., 84-10222 (5/87)
Mosier, Michael C., 85-05979 etc. (7/87)
Muchmore, Karen L., 85-11475 (6/87)
Mullenix, Monica J., 86-08086 (7/87)
Murray, Richard J., 85-03296 (9/87)
Murrhee, William T., 86-01675 (9/87)
Myers-Baker, Alice L., 86-03780 (9/87)
Nasery, Rabia S., 85-13312 etc. (2/87)
Neff, Leroy E., 86-04059 (9/87)
Nelson, James M., 85-07786 (8/87)
Newman, Kenneth, 85-08311 (4/87)
Newton, Heidi A., 86-02428 etc. (9/87)
Nguyen, Kim Van, 85-13392 (6/87)
Nicholson, Robert J., 85-06159 (6/87)
Noonkester, Randy A., 85-13902 (4/87)
Norcross, Joel R., 85-14892 etc. (7/87)
Norton, Barbara L., 86-05832 etc. (5/87)
Nutt, Brenda J., 84-04441 (4/87)
Oatney, Bill L., 86-03109 (9/87)
Olson, John S., 86-03884 (4/87)
Ortiz, Jose, 86-12837 (9/87)
Ostrander, Thomas J., 85-12424 (4/87)
Owen, Donald, 85-11351 etc. (9/87)
Owen, Marilyn D., 85-13072 etc. (5/87)
Owens, Jimmy D., 85-11278 (4/87)
Owsley (Karbonski), Sheila,85-13054 (6/87)
Palmer, Olivia R., 86-07258 (9/87)
Parker, Benny G., 85-10591 (8/87)
Parr, Chester W., 85-15247 etc. (1/87)
Paschelke, John L., 86-01292 (5/87)
Patterson, Michael R., 85-10700 (4/87)
Peck, Earl F., 85-13729 (4/87)
Pellett, Brenda, 85-16009 (9/87)
Perkins, Bradley H., 84-07465 (9/87)
Perry, Cleo F., 85-07195 (4/87)
Perry, Glenn L., 82-10387 etc. (5/87)
Peterson, Jack V., 86-05739 (9/87)
Peterson, James, 86-00341 (6/87)
Peterson, Janice E., 85-14668 (4/87)
Pettefer, Stephen R., 85-15019 (7/87)
Phelps, Robert J., 83-04150 (4/87)
Phetteplace, Robert C., 85-15446 (3/87)
Phillips, Gilbert F., 85-02772 (8/87)
Phillips, Gilbert F., 86-07281 (1/87)
Phillips, James M., 85-10622 (4/87)
Phillips, Wyatt E., 85-05341 (4/87)
Pierce, Rick S., 86-03686 (9/87)
Poore, Michael E., 85-11661 (7/87)
Porter, Deborah A., 85-03334 (2/87)
Porter, Mark O., 86-00027 (9/87)
Poulton, Dixie, 86-02130 (7/87)
Province, Vivian E., 86-10060 (9/87)
Pryce, Lisa A., 86-02295 (8/87)
Quintero, Ramona, 86-11504 (9/87)
Ramirez, Miguel A., 86-08067 etc. (6/87)
Razo, Christobal M., 86-02323 etc. (5/87)

Name, WCB Number (Month/Year)

Reeck, Randall W., 86-08407 (5/87)
Rehwalt, Daniel W., 85-08035 etc. (5,6/87)
Richey, Donald P., 86-06452 (4/87)
Riehl, Shelley D., 85-15306 (8/87)
Ritz, Henry P., 85-12593 (4/87)
Roark, James E., 84-02490 (5/87)
Roberts, Dorothy R., 86-10289 (9/87)
Roberts, John A., 86-04144 etc. (9/87)
Robinson, Jo C., 86-04099 etc. (6/87)
Rogers, Stephen A., 86-01028 (4/87)
Rogers, Steven L., 86-08765 (9/87)
Rojo, Roger M., 85-15887 (9/87)
Romero, Jose H., 86-00632 (9/87)
Rossback, Norman H., 84-13504 (6/87)
Rounsefell, Arlene M., 85-09341 (9/87)
Russell, Earl A., 86-04755 (5/87)
Russell, Nathan G., 85-04138 etc. (8/87)
Salinas, John E., 86-07536 (9/87)
Salleng, Kathleen S., 85-16061 (9/87)
Salyers, James R., 85-15982 (3/87)
Samples, Leonard E., 85-12565 (9/87)
Sanmann, Elaine R., 85-13259 (6/87)
Sardis, Magdalihna, 85-14295 (7/87)
Sarrica, George, 86-00617 (9/87)
Sauceda, Maria N., 83-08687 (2/87)
Schremm, Jodi A., 86-01124 (8/87)
Schroeder, Sana J., 86-17043 (9/87)
Schulz, Dallas L., 85-13433 (5/87)
Schweitz, Shirley A., 85-08480 (4/87)
Scott, Henry L., 84-10599 (4/87)
Sell, Michael A., 85-10498 (3/87)
Senters, Dale E., 84-10736 (6/87)
Settell, Clayton L., 86-01009 (4/87)
Shelton, Stella M., 85-12301 (7/87)
Shepherd, Allan T., 86-07450 etc. (9/87)
Simmons, Greg S., 85-13647 etc. (5/87)
Simpson, Linda, 86-01360 etc. (4,5/87)
Sims, Marvin L., 84-13313 (2/87)
Slater, David W., 85-02515 (8/87)
Slater, Norman, 85-14779 (3/87)
Slick, Daniel E., 85-16097 (5/87)
Slocum, Richard D., 86-07708 (9/87)
Smith, David A., 86-07492 (9/87)
Smith, Ervin L., 85-02407 (7/87)
Smith, George E., 85-08096 (8/87)
Smith, John F., 85-13742 (9/87)
Smith, Margaret A., 86-02102 (9/87)
Smith, Nevy E., 83-03240 (3/87)
Smith, Raymond G., Jr., 85-11849 (5/87)
Smith, Robert E., 85-12546 (5/87)
Smith, Russell L., 85-15653 etc. (7/87)
Smith, Vonda K., 86-00736 etc. (6/87)
Sorlie, Jodene A., 86-03924 (6/87)
Southwood, Norman D., 86-00815 (8/87)
Spear, Charles I., 86-02003 (9/87)
Spencer, Ronald E., 85-15331 (4/87)

Name, WCB Number (Month/Year)

Stafford, Donna M., 86-02374 (6/87)
Stanart, William L., 86-05734 (9/87)
Starr, Treva A., 85-14035 (6/87)
States, Connie M., 86-03926 etc. (5/87)
Steagall, George A., 86-04404 etc. (8/87)
Steele, Howard A., 86-03972 (8/87)
Steele, Thomas E., 85-10976 (8/87)
Steele, Vickey L., 86-05433 (8/87)
Steffen, Theresa L., 86-03966 (8/87)
Steiner, Raymond, 85-08935 (7/87)
Stephens, William W., 86-04462 (3/87)
Sterret, Richard P., 85-13095 (7/87)
Stickroth, Peggy A., 85-15036 (4/87)
Stowe, Steve C., 85-14812 (4/87)
Stratis, Angela M., 85-14407 (8/87)
Strickland, Michael, 85-04776 (4/87)
Strong, Dorothy H., 84-13576 (1/87)
Strosnider, Lewis B., 85-01588 etc. (9/87)
Stroup, Ernest A., 86-03327 (8/87)
Sturm, Phyllis J., 86-00542 (8/87)
Sullivan, Leslie M., 86-01727 (9/87)
Summey, Keith W., 86-09560 (9/87)
Swanson, Harry L., 85-15386 (5/87)
Tadlock, Mary L., 85-08068 (3/87)
Tanner, Linda M., 86-04519 (8/87)
Taylor, Lois, 84-10073 (8/87)
Taylor, Mary K., 86-07383 (5/87)
Thomas, Michael R., 85-05564 (4/87)
Thompson, Barbara J., 86-07856 (8/87)
Thompson, Bernard S., 85-13004 (6/87)
Thompson, Ernest E., 85-07828 (3,4/87)
Thorn, Thomas, 85-14940 (6/87)
Thornburg, Linda M., 85-05129 (4/87)
Tiffany, Dolores D., 86-08643 (9/87)
Tolson, Richard R., 85-05324 (5/87)
Tompkins, Darrell C., 86-06024 (9/87)
Tompkins, Lynette H., 84-12109 (3/87)
Torres, Enrique, 86-01971 (7/87)
Tracy, Glenn, 85-13394 etc. (4/87)
Tran, Russell G., 85-07037 (5/87)
Trebes, Thomas W., 85-11526 (5/87)
Trevino, Juanita R., 84-09490 (5/87)
Turner, Nancy E., 85-13919 (5/87)
Turpin, Larry L., 85-07971 (2/87)
Vargas, Alfred R., 86-04077 (7/87)
Villwock, Richard C., 85-10788 (7/87)
Vincent, Sharrone S., 85-01985 (4/87)
Voorhees, Michael G., 86-02853 etc. (7/87)
Wade, Fay W., 85-13030 (5/87)
Wagoner, Lenora A., 86-02676 (9/87)
Walker, Margaret A., 86-03960 (8/87)
Wallace, Jeffery E., 85-15372 (7/87)
Wallin, Millard W., 86-01382 (7/87)
Ware, Katie M., 85-11527 (4/87)
Warren, Irene A., 85-10404 (6/87)
Warwick, Christina M., 86-10539 (8/87)

Name, WCB Number (Month/Year)

Welch, K. Yvonne, 85-12956 (7/87)
West, Elsie J., 85-09518 (4/87)
West, Verda L., 86-01694 (9/87)
Westphal, David W., 84-03883 etc. (5/87)
Westphal, Jerald L., 86-02610 (8/87)
White, Daniel D., 86-05343 (4/87)
White, Donna J., 86-05604 (5/87)
Whitney, Harry C., 85-01078 (2/87)
Wilcox, Donald S., 85-05353 (8/87)
Wilder, Kristi L., 86-07468 (9/87)
Wilder, William, 85-14100 (8/87)
Wilkinson, Elizabeth, 85-10532 etc. (7/87)
Williams, Bonita J., 86-03383 (6/87)
Williams, Josephine, 86-00037 (7/87)
Williams, Margaret A., 85-08893 etc.(8/87)
Williams, Ronald, 86-00037 (7/87)
Willie, Beverly J., 86-01927 (6/87)
Willis, Carl E., 86-03744 (9/87)
Wilson, Gene L., 86-02922 etc. (7/87)
Wilson, Peggy, 85-08257 (4/87)
Wilson, Tamara D., 86-01820 (7/87)
Winegar, Jeffrey L., 85-11550 (3/87)
Wiser, Waymon, 85-15261 (7/87)
Wolever, Arlene F., 85-11460 (3/87)
Wolf, John P., 86-02445 (8/87)
Wood, Michael G., 85-15746 (4/87)
Woodbury, Ola F., 86-02262 etc. (3/87)
Wooden, Suzanne M., 86-06218 etc. (7/87)
Wright, Garland V., 86-00784 etc. (9/87)
Wright, Leroy F., 85-09370 (8/87)
Wyckoff, Robert R., 84-07453 (6/87)
Yegge, Kim, 85-15316 (9/87)
Yoas, Kathryn M., 85-13130 (9/87)
York, Michael O., 85-08429 etc. (6/87)
Zimmerman, Evelyn E., 86-05282 (4/87)

The following decisions under 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 1987

Name, WCB Number (Month/Year)

Abbott, Don L., 87-0216M (4,7/87)
Abraham, Alfred C., 86-0664M (2/87)
Ackerman, Sharon K., 87-0420M (8/87)
Adams, Finis O., 85-0419M (1/87)
Adams, Logan A., 87-0252M (6/87)
Albrecht, William, 87-0440M (9/87)
Albro, Steven E., 87-0334M (8/87)
Alderman, Herb L., 86-0199M (3/87)
Aldous, Edward, 86-0390M (2/87)
Alfano, Tony E., 87-0237M (6/87)
Allen, Joseph C., 86-0263M (3/87)
Allen, Wendy S., 86-0451M (3/87)
Allwander, Charles H., 86-0655M (2/87)
Anderson, David W., 86-0470M (2,2/87)
Anderson, Don L., 86-0330M (5,9/87)
Anderson, Joseph A., 83-0160M (3/87)
Anderson, Susan, 87-0153M (8/87)
Andrade, Albert Y., 87-0084M (2/87)
Ansbro, James C., 87-0382M (7/87)
Antonio, Audrey Burton, 87-0279M (6/87)
Armstrong, John S., 86-0671M (2/87)
Arnett, Edward R., 86-0376M (7,9/87)
Arnold, Marc L., 86-0280M (9/87)
Arrant, Leonard, 87-0233M (4,9/87)
Arroyo, Sam R., 86-0649M (2/87)
Arvidson, George L., 84-0581M (8/87)
Ash, John A., 87-0364M (6/87)
Atkins, Dale E., 87-0238M (4/87)
Baalman, Nicholas A., 87-0315M (6,9/87)
Bailey, Claude, 85-0030M (6,9/87)
Bailey, David J., 87-0435M (9/87)
Baker, Anthony, 87-0041M (1,2/87)
Baker, Barbara E., 86-0045M (1/87)
Baker, Howard A., 87-0293M (5/87)
Baker, Steven, 87-0200M (4/87)
Baldwin, Raymond L., 87-0034M (3,8/87)
Ball, John A., 86-0630M (1/87)
Baller, Debra A., 86-0543M (2/87)
Bangs, Jim, 87-0038M (4/87)
Bangs, Larry G., 87-0314M (7/87)
Banta, Wayne A., 87-0524M (9/87)
Barnes-Lentz, Mildred, 86-0071M (5/87)
Barnett, Tom L., 85-0038M (1,8/87)
Barney, Frank H., 86-0192M (7/87)
Barrera, David G., 87-0430M (8/87)
Beavers, Clyde, 87-0012M etc. (1/87)
Belle, Anna R., 87-0027M (6/87)
Bender, Wilma S., 86-0567M (5/87)
Bennett, Linda L., 86-0243M (6/87)
Bennett, Ronald E., 84-0109M (6/87)
Benton, James E., 87-0228M (5/87)
Berger, Carl P., 87-0017M (1,2/87)
Bergmen, Clark A., 87-0532M (9/87)
Best, Curtis, 87-0401M (8,9/87)
Bias, Richard L., 86-0708M (5/87)
Bigby, George S., 87-0254M (5/87)
Bigelow, Grant W., 87-0327M (6/87)
Bigsby, Barbara, 86-0368M (3/87)
Billings, Gerald L., 87-0325M (6/87)
Billups, Terry L., 85-0271M (2,6,9/87)
Birchmier, Douglas, 87-0026M (1/87)
Bishop, Monica, 87-0168M (3/87)
Bittner, Edward A., 86-0668M (2/87)
Blacketer, Kenneth R., 87-0135M (4,7/87)
Blair, Joyce D., 87-0310M (6,9,9/87)
Blakely, Bobbie J., 85-0177M (2/87)
Blakely, Randy L., 86-0455M (5/87)
Blank, Michael T., 86-0548M (3,3/87)
Blanton, John, 87-0284M (9/87)
Blaylock, James S., 87-0053M (2/87)
Blevins, Jack, 87-0371M (8/87)
Blondell, Curtis, 87-0215M (9/87)
Bodda, Harvey, 87-0312M (9/87)
Bogue, Dick E., 87-0541M (9/87)
Booher, Raymond C., 87-0129M (6/87)
Booth, Larry A., 86-0408M (6,9/87)
Booth, Stephen B., 87-0235M (4/87)
Borisoff, Henry T., 87-0404M (9/87)
Borkowski, Kenneth R., 86-0583M (4/87)
Bostwick, Harry R., 87-0441M (8/87)
Boyce, Lloyd C., Jr., 84-0242M (3/87)
Boyd, Danny L., 87-0142M (3/87)
Boyles, Gary T., 86-0496M (7/87)
Brakefield, Juanita J., 85-0143M (6/87)
Branca, Richard W., 87-0390M (8/87)
Brant, Hilda, 85-0667M (8/87)
Braun, Donald J., 87-0196M (5,7/87)
Breazeale, Jerry W., 86-0452M (3,3,7/87)
Breese, Donald E., 87-0360M (8/87)
Brenner, John R., 85-0090M (7/87)
Bridges, Velton L., 81-0049M (5/87)
Brieger, Donald N., 85-0252M (2/87)
Brockie, Robert W., 87-0292M (8/87)
Brookshire, Joy J., 86-0689M (2/87)
Broughton, Emmett, 87-0167M (5/87)
Brown, Charles E., 86-0637M (2/87)
Brown, Dorothy, 87-0224M (4,5/87)
Brown, Gary O., 84-0266M (2/87)
Brown, Robert W., 87-0143M (3/87)
Brown, Roger T., 87-0130M (5/87)
Bryce, Mary, 86-0546M (8/87)
Buchanan, Patrick L., 86-0278M (4/87)
Buck, Nicholas J., 83-0296M (5,8/87)
Bunch, Shirley A., 86-0140M (1/87)
Burgess, Curtis A., 86-0677M (6/87)
Burgess, Paul H., 87-0351M (9/87)
Burres, Joseph L., 86-0614M (1,7/87)
Bush, Daniel L., 87-0043M (1/87)
Bush, Ernest M., 87-0333M (6/87)

Name, WCB Number (Month/Year)

Butler, June M., 87-0474M (9/87)
Butler-Reeves, Kathleen, 87-0432M (9/87)
Caccamise, Chris, 86-0680M (8/87)
Cady, Clare, 87-0225M (6/87)
Cady, Lester F., 87-0123M (4/87)
Calkins, Charles R., 85-0127M (1/87)
Calkins, Kenneth W., 86-0632M (8/87)
Cambron, Connell R., 86-0703M (1/87)
Cameron, Scott L., 87-0076M (3/87)
Carden, Richard D., 87-0422M (9/87)
Carr, Iola P., 86-0706M (3,5/87)
Carrier, Glen A., 86-0701M (1,5,8/87)
Carroll, Eldon L., 86-0078M (2,5/87)
Carter, Donald C., 86-0482M (1,6/87)
Carter, Dorothy R., 87-0060M (3,9/87)
Carter, Ronald R., 87-0294M (8/87)
Casey, Georgia, 87-0113M (2/87)
Castle, Melvin O., 84-0267M (3/87)
Catto, Dale E., 87-0182M (3/87)
Center, Gary D., 87-0536M (9/87)
Cerkoney, Patricia J., 86-0099M (3/87)
Chambers, Lester R., 86-0667M (2/87)
Chandler-Tawney, Theda M., 87-0031M (1/87)
Chaney, Orvel L., 87-0290M (5/87)
Cheatham, Verla L., 87-0534M (9/87)
Chew, Vernon, 83-0376M (8/87)
Childers, Larry L., 86-0611M (6/87)
Choi, Sook Ja, 86-0300M (1/87)
Clancy, Patrick, 87-0348M (8/87)
Clark, Bobby R., 87-0057M (1,3,9/87)
Claussen, Karen, 86-0549M (1,2,3/87)
Clevenger, Delmer, 87-0510M (9/87)
Clough, Robert L., 85-0329M (9/87)
Coats, Thomas R., 87-0242M (4/87)
Cobb, Vernon G., 86-0529M (1/87)
Coen, Daniel E., 85-0532M (3/87)
Coiteux, Linda M., 87-0170M (8/87)
Collins, Donna L., 85-0154M (5/87)
Comer, Sandra L., 87-0112M (2/87)
Connary, Harold David, 87-0229M (4/87)
Cooper, Iran P., 87-0423M (9/87)
Cooper, Kathryn, 87-0011M (3/87)
Cooper, Leo, 84-0035M etc. (6,6,7/87)
Copher, Edwin L., 86-0669M (3/87)
Cornett, Marvin, 85-0601M (6/87)
Corwin, Jack L., 86-0635M (8/87)
Cottam, Linda H., 86-0697M (2/87)
Couch, Billie D., 87-0322M (8/87)
Cox, Georgia, 87-0067M (4/87)
Cox, Joseph L., 86-0141M (3/87)
Crawford, Richard, 87-0324M (6/87)
Cress, Stanley, 87-0443M (8/87)
Crickmer, Micheal, Jr., 87-0311M (9/87)
Crossley, William F., 84-0533M (3/87)
Crouch, Michael, 87-0522M (9/87)
Cummins, Mary Jo, 87-0096M (2/87)
Cutright, Florence Paulsen,87-0264M (8/87)
Cutsforth, Barbara J., 87-0052M (1/87)
Dale, William J., 87-0029M (2/87)
Dalton, Robert W., 86-0436M (8/87)
Danielson, James L., 87-0259M (5/87)
Darby, Lena R., 87-0039M (3/87)
David, Charlie E., 87-0416M (9/87)
Davidson, Robert A., 87-0188M (4/87)
Davis, Craig J., 87-0178M (3/87)
Davis, Ivan, 87-0146M (4/87)
Dawley, Frank, 87-0218M (4/87)
Dearmond, Gayford N., 87-0475M (9/87)
Dees, Glenn R., 86-0410M (3,4/87)
Derting, Luther E., 87-0514M (9/87)
Diaz, Barbara A., 87-0154M (3/87)
Dilworth, William C., 85-0050M (3,5/87)
Dobbs, Michael, 87-0329M (9/87)
Dobson, Dennis A., 87-0213M (4,9/87)
Dodrill, Donald L., 85-0410M (7/87)
Doggett, Kenneth M., 86-0590M (1/87)
Dorrenbacher, Billy J., 85-0552M (8/87)
Dorsey, Terry E., 84-0372M (3/87)
Douglass, Paul, 87-0285M (6/87)
Dove, Jean L., 87-0082M (3/87)
Dowell, Carol Ann, 85-0258M (5/87)
Dugan, Timothy, 86-0662M (6/87)
Duncan, Earl M., 87-0386M (7/87)
Duncan, James A., 86-0522M (8/87)
Durbin, Dave, 87-0316M (8/87)
Duren, Bradley D., 87-0370M (8/87)
Dusenberry, Sam A., 87-0087M (2/87)
Dutton, Douglas L., 87-0267M (8,9/87)
Early, Robert F., 87-0338M (6/87)
Eastburn, Susan E., 87-0497M (9/87)
Ehly, Ronald R., 86-0089M (1/87)
Ehmke, Pamela, 87-0270M (9/87)
Elkins, Garry, 87-0302M (5,8/87)
Elliott, Norma J., 87-0021M (1,2/87)
Ellis, Loretta M., 87-0044M (1/87)
English, Carroll D., 87-0205M (6/87)
English, James C., 87-0160M (3/87)
Erdahl, Charles L., 85-0456M (7/87)
Erwen, Ted N., 86-0501M (8/87)
Evans, Arnold "Gene", 86-0385M (1/87)
Fake, Theodore M., 85-0495M (1/87)
Farrens, Gerald R., 87-0289M (5/87)
Farson, Patricia A., 87-0452M (9/87)
Faughn, Darrell, 86-0551M (3,4,8/87)
Felton, Roxy Dean, 87-0071M (3/87)
Ferebee, John, 87-0208M (8/87)
Fields, Eddie, 84-0536M (8/87)
Firestone, James M., 86-0403M (1/87)
Fisher, Glenn, 87-0214M (4/87)
Fisher, Richard N., 87-0278M (5/87)
Fitzgerald, Gayle, 87-0471M (8,9/87)
Fitzgerald, Jack, 87-0414M (8/87)
Fix, Paul D., 86-0617M (2,6/87)
Flescher, Benjamin R., 86-0573M (1/87)
Fletcher, O.C., 86-0679M (2/87)
Flory, Hazel P., 87-0230M (4/87)

Name, WCB Number (Month/Year)

Foltz, Doyle C., 84-0148M (6/87)
Folwick, Marty R., 87-0173M (5/87)
Ford, Donald F., 87-0385M (7/87)
Fortenberry, Phillip G., 86-0541M (4/87)
Foster, Howard S., 87-0525M (9/87)
Fourier, Shirley L., 86-0279M (1/87)
Frame, Earl F., 86-0650M (1/87)
Frame, Earl F., 87-0181M (8/87)
France, Roger G., 85-0310M (3/87)
Franke, Donald M., 86-0097M (4/87)
Frazier, Ather, 87-0291M (5/87)
Frazier, Scott, 87-0551M (9/87)
Frear, James, 85-0675M (7/87)
Frederick, Carl J., 86-0684M (4/87)
Freimuth, Leslie, 87-0222M (5/87)
Fruichantie, Jerry, 87-0025M (2/87)
Fuestman, Beatrice, 87-0317M (6/87)
Funk, William, 87-0227M (4,8/87)
Gall, Teresa A., 87-0189M (4/87)
Gallegos, Lynda M., 87-0295M (7/87)
Gardner, Leland R., 86-0249M (4/87)
Garrison, Dale A., 86-0515M (3/87)
Gaspard, Joy J., 87-0056M (1/87)
Gatens, Lester W., 86-0461M (5,5,7,8/87)
Gates, David E., 87-0239M (4/87)
Gay, Lloyd, 87-0202M (6/87)
Gay, Walter, 86-0130M (5/87)
Gearin, Fred, Jr., 87-0460M (8/87)
Geenty, Richard T., 83-0313M (4/87)
Gentry, Wayne N., 85-0347M (1/87)
Geving, Snowden A., 87-0090M (4/87)
Gibbs, Daniel, 87-0134M (7/87)
Giesbrecht, Robin, 86-0699M (2/87)
Gieszler, Kwito, 86-0528M (8/87)
Gifford, Elizabeth, 86-0353M (3/87)
Gigoux, John A., 87-0439M (8/87)
Gilder, Kenneth, 85-0682M (9/87)
Gilkey, Arlene, 87-0255M (5,6/87)
Gill, Charles, 87-0489M (9/87)
Gilman, Charles A., 86-0251M (1,6/87)
Gimlin, Rick L., 87-0138M (3/87)
Giorgetti, Rudy L., 87-0207M (4/87)
Gipson, DeWayne P., 85-0537M (5/87)
Glazier, Leonard R., 86-0531M (1/87)
Glover, Berenice C., 87-0119M (3/87)
Gordineer, Harley J., 87-0336M (6/87)
Gower, Earl C., 86-0381M (3/87)
Graham, Johnnie T., 87-0133M (4/87)
Graham, William H., 87-0115M (9/87)
Grant, Maxine, 87-0023M (2/87)
Graves, Peggy J., 87-0498M (9/87)
Green, Coral, 87-0342M (8/87)
Gregg (Freeman), Laurie, 87-0180M (3/87)
Gregory, Daniel G., 85-0407M (5/87)
Grendler, Jean M., 86-0303M (1/87)
Griswold, Debra, 85-0579M (4/87)
Groat, Jerry D., 87-0512M (9/87)
Grover, Leroy J., 87-0081M (2/87)
Gruber, Larry, 87-0262M (5/87)
Guerci, Elizabeth, 87-0069M (3/87)
Guernsey, Craig H., 86-0672M (1/87)
Guerrette, Patsy J., 85-0658M (3/87)
Gunn, Steven C., 86-0222M (1/87)
Gutierrez, Mario, 87-0245M (8/87)
Gutierrez, Santos, 87-0116M (2,9/87)
Gymkowski, Joseph, Jr., 87-0282M (5,8/87)
Hagedorn, Nana D., 87-0527M (9/87)
Hager, James J., 87-0077M (2/87)
Halter, Paula, 87-0094M (2/87)
Hamm, James E., 87-0277M (8/87)
Hammer, Jack L., 86-0444M (7,9/87)
Hancock, Jancy K., 87-0152M (6/87)
Hancock, Lee R., 86-0525M (1/87)
Hanson, Craig R., 86-0535M (1,1/87)
Hanson, David A., 87-0093M (2,4/87)
Hardenbrook, James M., 86-0434M (1/87)
Harlin, Betty, 87-0516M (9/87)
Harris, Jack G., 86-0060M (3/87)
Harris, John, 87-0078M (2/87)
Harris, Paul A., 87-0047M (3/87)
Harris, Rex A., 86-0606M (2/87)
Harris, Robert S., 87-0397M (9/87)
Harvey, Herman, Jr., 87-0521M (9/87)
Haskett, Merritt W., 87-0425M (8/87)
Hawkins, John H., 87-0158M (4/87)
Hayes, Larry L., 85-0393M etc. (3,9/87)
Hedgpeth, Ruth, 87-0353M (8/87)
Hegele, Charles G., 87-0109M (6/87)
Heggstrom, Charles E., 86-0259M (1/87)
Heilman, Robert L., 87-0194M (4/87)
Heintz, Edward V., 87-0494M (9/87)
Henderson, Nonda, 86-0503M (8/87)
Hendrick, David W., 87-0018M (2/87)
Hendricks, James, 86-0640M (5/87)
Hendrickson, Shirley, 86-0169M (3/87)
Hendrix, Calvin K., 86-0050M (4/87)
Henry, Donald W., Jr., 87-0032M (8/87)
Herron, James M., 86-0466M (1/87)
Hibbs, Wallace, 87-0220M (5/87)
Hickman, Donald, 87-0147M (4/87)
Hicks, Carl W., 87-0413M (8/87)
Higa, Harold T., 86-0711M (1/87)
Higgins, Roger L., 87-0346M (9/87)
Hilderbrand, James R., 86-0012M (9/87)
Hill, David, 87-0001M (5/87)
Hill, Raymond D., 87-0051M (1,4/87)
Hilton, Alice L., 87-0132M (3,8/87)
Hinton, Larry A., 86-0695M (6/87)
Hinzman, Bernie, 83-0097M (8/87)
Hissner Graham, Shirley A.,87-0166M (3/87)
Hlavka, Joseph, 87-0184M (8/87)
Hodges, Leona Mabel, 87-0206M (8/87)
Hodges, Thomas, 87-0462M (9/87)
Hoff, Harley R., 84-0032M (9/87)
Hoiting, Lawrence H., 85-0594M (2/87)
Hoke, Harold L., 84-0476M (9/87)
Holland, Walter, 86-0354M (4/87)
Holloway, James N., 86-0603M (2/87)
Holman, David R., 86-0437M (6,9,9/87)

Name, WCB Number (Month/Year)

Holme, Marie, 86-0131M (2/87)
Holmes, Loren D., 87-0176M (5/87)
Holmstrom, Paul, 87-0155M (3/87)
Howard, Richard H., 81-0252M (5/87)
Howlan, Larry E., 87-0221M (4/87)
Hubbard, Edward, 86-0431M (2/87)
Huck, Brett W., 87-0049M (5/87)
Hudspeth, William R., 86-0710M (1/87)
Huffman, Milford W., 84-0461M (3,5/87)
Hunter, David O., 86-0218M (3/87)
Hurley, Garold L., 86-0628M (2,3/87)
Hurt, Louise, 87-0085M (3/87)
Idlewine, James, 86-0122M (8/87)
Imbler, George L., 85-0486M (7/87)
Irving, Lynn B., 87-0266M (7,7/87)
Jackson, Margarite, 84-0256M (6/87)
Jackson, Robert, 87-0185M (4,8,9/87)
Jacobe, Joyce A., 87-0211M (4/87)
Jacobson, Bert N., 85-0648M (1,6/87)
Jaramillo, Richard J., 87-0261M (6/87)
Jeffers, Donald W., 86-0476M (9/87)
Jensen, Leonard J., 86-0694M (3,4/87)
Jensen, Rex D., 87-0480M (8/87)
Johnson, Clayton W., 87-0241M (4,5/87)
Johnson, Dennis L., 87-0349M (7/87)
Johnson, Frances L., 87-0046M (1/87)
Johnson, Robert V., 87-0339M (7/87)
Johnson, Roy W., 87-0502M (9/87)
Johnson, Stella, 87-0212M (9/87)
Johnstone, Michael C., 86-0707M (4,6/87)
Jones, Charles C., 86-0576M (1/87)
Jones, Dennis J., 86-0651M (1/87)
Jones, Tim L., 87-0431M (8/87)
Jordan, George W., 87-0131M (5/87)
Jorgenson, Patricia A., 87-0320M (8/87)
Joseph, Elaine T., 87-0103M (4/87)
Joseph, Elaine T., 87-0394M (8/87)
Kaiser, Michael J., 87-0513M (9/87)
Karna, Linda Dyer, 86-0306M (9/87)
Katzberg, Ronald L., 86-0272M (5/87)
Kay, Leonard D., 87-0223M (6/87)
Keller, Edwin Lee, 87-0075M (8/87)
Kelley, James K., 87-0450M (8/87)
Kellogg, Lawrence L., 86-0607M (1/87)
Kelly, Jack L., 87-0114M (5/87)
Kelly, Robert W., 86-0561M (1/87)
Kelly, Roy E., 86-0321M (1/87)
Kendrick, John C., 86-0370M (4/87)
Kennedy, Dewey, 85-0476M (8/87)
Kennedy, Richard G., 87-0118M (9/87)
Kennedy, Robert E., 86-0629M (1,9/87)
Kennison, Gerald L., 85-0574M (8/87)
Kester, Clifford L., 86-0102M (1/87)
Kinaman, Jerry W., 85-0078M (6/87)
King, Edna L., 86-0574M (1/87)
King, Walter F., Jr., 86-0425M (2/87)
Kinsey, Jerry, 86-0283M (9/87)
Kissee, Ted R., 87-0519M (9/87)
Klein, Larry, 87-0028M (2,2/87)
Knight, Robert A., 86-0363M (7/87)
Knowlson, James C., 86-0666M (8/87)
Kociemba, Leroy A. (6,6/87)
Koehler, Audrey, 87-0175M (3/87)
Koehn, Fred L., 87-0483M (8/87)
Koenig, Phillip D., 87-0232M (4/87)
Koho, Kay E. (Tucker), 87-0157M (3,4/87)
Kroner, Lloyd A., 87-0449M (8/87)
Kundelius, Anthony, 87-0301M (6/87)
Labahn, Arthur J., 85-0334M (3/87)
Landers, Arthur W., 86-0402M (2,6/87)
Landis, Allen, 87-0405M (8/87)
Laney, Walter, 84-0185M (6/87)
Lang, Christine A., 87-0347M (7/87)
Lang, Terry L., 84-0434M (4/87)
Langton, Thomas L., 87-0102M (4/87)
Lanz, Ray J., 86-0506M (5/87)
Larson, Frank E., 86-0686M (1,7/87)
Larson, Leonard, Jr., 86-0398M (1/87)
Lauritsen, Kerry L., 86-0570M (1,6/87)
Lawrence, W.E., 87-0383M (7/87)
Laxson, Lindsay B., 87-0177M (3/87)
Leach, Jack E., 87-0219M (5/87)
LeClaire, Nelson, 86-0545M (3,6/87)
Lee, Terry G., 87-0453M (9/87)
Lehn, Randall W., 86-0145M (5/87)
Lehnherr, John, 86-0676M (5,6/87)
Leigh, Kenneth, 86-0233M (4/87)
Leighton, James W., 86-0340M (1/87)
Lentz, Gordon L., 85-0637M (8/87)
Leonetti, Gregg J., 87-0198M (4,4/87)
Lesh, Lynn, 86-0624M (1/87)
Lichau, James W., 86-0538M (2/87)
Lindberg, Darylene M., 86-0366M (1,9/87)
Little, Larry L., 87-0361M (6/87)
Littleton, Richard, 87-0145M (3/87)
Lloyd, John, 87-0446M (8/87)
Lofton, Calvin, 85-0663M (3/87)
Loftus, Diane, 87-0538M (9/87)
Logan, Mitchell J., 87-0072M (8/87)
Lomas, Michael H., 87-0319M (6,7/87)
Lombardi, Linda L., 87-0389M (8/87)
Longanecker, Orval, 86-0491M (8/87)
Loudon, Joanne L., 86-0642M (1,6/87)
Louvring, Gordon E., 87-0343M (6/87)
Lovan, Herman, 87-0546M (9/87)
Lucas, Craig M., 85-0643M (4/87)
Lucky, Gary D., 87-0015M (3,6/87)
Lundy, Clyde D., 87-0156M (3,5/87)
Lutes, Stephen G., 87-0201M (4/87)
Lutz, Brian K., 87-0050M (8/87)
Lyons, Charles G., 86-0133M (2/87)
Madigan, John B., 87-0006M (1/87)
Malar, Shirley E., 87-0070M (5/87)
Mandzij, Della, 87-0121M (3,8/87)
Manning, Larry D., 87-0448M (8/87)
Marsh, Bruce A., 86-0356M (2/87)
Marshall, Edward F., 86-0682M (2/87)
Martin, Elson, 87-0402M (7/87)

Name, WCB Number (Month/Year)

Martin, Niel P., 86-0620M (3/87)
Martinez, Armando, 86-0252M (2,7/87)
Mathes, Patsy, 87-0024M (3/87)
Matson, Patricia E., 86-0619M (1/87)
Matthews, Ned, 87-0126M (3/87)
Maupin, Eddy V., 87-0122M (6/87)
May, George R., 87-0136M (6/87)
McAlister, J.D., 86-0388M (2,6,8/87)
McClaurin, Jenevieve, 86-0395M (3/87)
McCormick, Kathy B., 87-0144M (3/87)
McCready, Mary, 87-0344M (6/87)
McFadden, James H., 87-0359M (6/87)
McGhee, Arthur V., 87-0408M (8,9/87)
McGhee, William W., 87-0079M (3/87)
McGill, Harvey, 87-0263M (5/87)
McGrory, A. Brendan, 85-0551M (1,4/87)
McKay, Candy K., 87-0273M (5/87)
McKenney, Robert G., 87-0097M (3/87)
McMahill, Ronald L., 86-0581M (8/87)
McMullen, Alan H., 87-0005M (1/87)
McNamara, Ronald E., 87-0461M (9/87)
McWilliams, Bertha, 87-0384M (9/87)
Meadors, Shuler M., 87-0151M (5/87)
Meek, Joseph L., 86-0663M (1,9/87)
Meeuwsen, Christiana H., 86-0039M (2/87)
Mercier, Darrel L., 87-0179M (4,5/87)
Merrill, Sally, 86-0469M (3/87)
Messer, George R., 86-0692M (2/87)
Meyer, Robert, 86-0305M (3/87)
Michael, Vernon, 81-0201M (6/87)
Mikolajczak, James J., 87-0465M (8/87)
Miley, James D., 87-0369M (7/87)
Miller, Beverly L., 87-0236M (5/87)
Miller, David R., 87-0204M (5/87)
Miller, Delbert J., 87-0064M (1/87)
Miller, Donald K., 85-0033M (6/87)
Miller, George Irving, 87-0217M (5/87)
Miller, Harry M., 87-0105M (4,6/87)
Miller, Mildred P., 86-0705M (3,7/87)
Miller, Steven D., 85-0010M (6/87)
Mills, Dennis, 87-0030M (1,6/87)
Mindt, Herbert, 87-0517M (9/87)
Minnick, Gary L., 87-0426M (8/87)
Mitchell, Karl E., 86-0064M (3,6/87)
Modaff, George A., 86-0304M (1/87)
Monroe, Jack G., 86-0327M (5/87)
Moon, Carroll C., 85-0316M (7/87)
Moore, Clayton, 85-0549M (5/87)
Moore, Jack D., 86-0609M (1/87)
Morley, Ralph W., 86-0638M (2,8/87)
Morris, Christopher M., 87-0392M (8/87)
Morris, Clifton G., 86-0601M (2,5/87)
Morrison, Howard E., 87-0124M (6/87)
Mowry, Robert L., 85-0131M (9/87)
Muir, Michael, 87-0150M (4/87)
Mullen, Gary L., 87-0481M (9/87)
Mullen, Lois, 87-0299M (6/87)
Murphey, Charles E., 85-0217M (6/87)
Murphy, Darreld R., 87-0148M (4,7/87)
Mustoe, Erwin R., 83-0388M (3/87)
Neal, James W., 86-0462M (1/87)
Neault, Marji M., 87-0190M (5/87)
Nelson, Mary E., 86-0652M (2/87)
Newingham, Donald F., 87-0091M (4/87)
Newkirk, Ellena D., 87-0098M (3/87)
Newson, Robert L., 85-0585M (7/87)
Nichols, Joe, 87-0503M (9/87)
Nipper, H. Elvis, 87-0482M (9/87)
Noggle, Richard, 87-0073M (6/87)
Norrander, Ralph H., 87-0007M (1/87)
Nunez, Gary G., 86-0685M (1/86)
O'Connor, Bernard M., 87-0478M (8/87)
O'Keefe, Daniel, 86-0474M (2/87)
Ochampaugh, William, 87-0199M (8/87)
Oiler, Jimmie D., Jr., 86-0505M (3/87)
Oland, Delmar, 87-0037M (1/87)
Oliver, J.C., 87-0055M (1,5/87)
Olsen, Mary M., 85-0309M (8/87)
Olson, Allan D., 84-0161M (5/87)
Olson, Robert O., 85-0297M (5/87)
Osborn, Rachel B., 85-0465M (6,8/87)
Ownby, Laurena, 84-0324M (6/87)
Pace, Lynda R., 87-0323M (6/87)
Palmer, James F., 87-0286M (7/87)
Palomo, Victor, 86-0621M (2/87)
Papaioannou, Theodoros, 87-0381M (7/87)
Parker, Lee Roy, 87-0065M (3/87)
Parks, Delbert W., 87-0313M (5/87)
Parr, Robert A., 87-0165M (4/87)
Parrett, Robert, 87-0451M (8/87)
Parrish, Delano C., 87-0159M (3/87)
Partida, Frank, 86-0623M (5/87)
Passmore, George G., 87-0345M (6/87)
Patterson, Archie B., 84-0285M (5/87)
Peabody, Rick B., 86-0704M (1/87)
Peacock, James, 87-0062M (2,3,4/87)
Peacock, Stephen J., 87-0362M (7/87)
Pedersen, Robert D., 87-0193M (5/87)
Pederson, John L., 87-0376M (8/87)
Perisho, Zenas A., 87-0409M (8/87)
Perkins, Bradley H., 85-0694M (9/87)
Perry, Robert, 87-0506M (9/87)
Peters, Fred, 87-0444M (9/87)
Peterson, Leonard, 87-0066M (3/87)
Peterson, Marlene E., 86-0024M (7/87)
Pfau, Peter A., 86-0594M (3/87)
Pfleuger, Becky, 86-0593M (4,7/87)
Phillips, Donald, 87-0380M (7,9/87)
Phillips, Richard C., 87-0463M (8/87)
Phillips, Robert G., 87-0251M (8/87)
Pickering, D. Stephen, 86-0688M (9/87)
Pierson, Georgia L., 87-0377M (7/87)
Pinkham, Berkley Joe, 86-0625M (3/87)
Pishion, Herbert O., 87-0231M (8/87)
Pittman, Beulah, 87-0505M (9/87)
Pitts, Carl D., 86-0508M (2,4/87)

Name, WCB Number (Month/Year)

Poelwijk, James, 86-0627M (5,5/87)
Pollock, Joseph, 87-0526M (9/87)
Porter, Darrell, 86-0661M (6/87)
Porter, Harris H., 87-0244M (5/87)
Potts, Clarence, 87-0469M (8/87)
Potts, Robert D., 85-0491M (8/87)
Powell, James H., 87-0045M (1,9/87)
Prettyman, Earl J., 87-0495M (9/87)
Prian, Joseph D., 86-0372M (1,3,7/87)
Priddy, Vernon D., 87-0137M (3/87)
Prince, Larry E., 87-0468M (8/87)
Pritchard, Debra K., 86-0240M (8/87)
Prock, Peggy, 87-0303M (7/87)
Puckett, Elfreta R., 87-0367M (9/87)
Puckett, Robert V., 87-0400M (8/87)
Queener, Gary, 86-0646M (1,3/87)
Quimby, David, 85-0565M (2/87)
Rackley, Gene, 86-0690M (3/87)
Ragland, Johnny, 86-0277M (3/87)
Randahl, Keith D., 86-0236M (1/87)
Randall, Grace M., 87-0016M (6/87)
Randall, Lindi G., 87-0268M (5/87)
Rautenberg, Larry L., 85-0205M (1/87)
Ray, Esther B., 86-0287M (3/87)
Ray, James R., 85-0057M (5/87)
Reed, Robert R., 87-0457M (9/87)
Reeves, Marsdell, 86-0309M (6/87)
Reid, Albert W., 87-0059M (3/87)
Rekow, Michael R., 87-0186M (4/87)
Remund, Sharon M., 87-0256M (5/87)
Reynolds, Becky J., 87-0427M (9/87)
Rhodes, Hoover, 87-0110M (3/87)
Rice, William L., 87-0099M (2/87)
Richards, Stanley L., 87-0210M (4/87)
Rimer, Robert, 87-0485M (9/87)
Roberts, Starlee E., 86-0391M (2/87)
Rogers, Brian M., 87-0010M (1,5/87)
Rogers, Gayle Keith, 85-0654M (5/87)
Rogers, Richard, 85-0600M (2/87)
Roller, Charles W., 87-0337M (6/87)
Roppe, Arthur D., 85-0106M (8/87)
Ross, Wiley G., 85-0454M (1/87)
Rost, Lou A., 86-0494M (1/87)
Rottacker, Natalie, 86-0223M (5,6/87)
Roundy, Lee M., 87-0388M (7/87)
Roush, Richard L., 84-0018M (6,8/87)
Rowan, John T., 86-0413M (1,3/87)
Royer, Peggy A., 86-0399M (2/87)
Roylance, Jerry R., 87-0048M (2/87)
Ruff, Jerry, 86-0460M (8/87)
Salinas, John E., 86-0485M (2/87)
Salinas, Rosalio L., 87-0466M (8/87)
Salsgiver, Joseph C., 86-0660M (8/87)
Salzer, Sharon, 86-0070M (3,4,5,6/87)
Sampson, Fred T., 87-0528M (9/87)
Samudio, Rudolph, 87-0326M (6/87)
Sanborn, Rodney L., 86-0589M (1/87)
Sandusky, Richard F., Jr., 87-0009M (1/87)
Sarduy, Jorge L., 87-0111M (2/87)
Sayre, Eugene, 86-0190M (3/87)
Schaffer, Lucine T., 87-0234M (5/87)
Schmid, Kenneth G., 86-0618M (1/87)
Schram, Debra L., 86-0069M (3,4/87)
Schultz, Clayton R., 87-0246M (4/87)
Schulze, Ruby, 87-0406M (9/87)
Scott, Elva L., 87-0391M (9/87)
Scott, Jeffrey J., 87-0249M (5/87)
Scroggins, Ronald D., 87-0004M (1,4,9/87)
Seaberry, Henry, 87-0395M (8/87)
Sears, Ardith DeJong, 87-0101M (8/87)
Sease, David A., 86-0498M (1/87)
Sebastian, Delores Jean, 87-0107M (3,6/87)
Seehafer, Douglas, 85-0504M (5/87)
Self, Ira D., 86-0242M (5/87)
Serna, Guadalupe, 87-0058M (6/87)
Sevey, Julius B., 86-0569M (1/87)
Shaw, Catherine R., 87-0318M (6/87)
Shaw, Terri Zemp, 87-0195M (4,6,8/87)
Shelden, Vernon, 86-0495M (5/87)
Shepherd, Donna, 87-0518M (9/87)
Sheythe, Keith E., 87-0374M (7,8/87)
Shilling, Donna J., 86-0302M (3/87)
Shipman, Orville D., 86-0653M (1/87)
Shipman, William L., 87-0074M (2,3/87)
Short, Kenneth, 86-0387M (6/87)
Short, Lloyd, 87-0274M (7/87)
Shreeve, George, Jr., 86-0678M (2,9/87)
Shrum, Jean A., 86-0550M (1/87)
Sidener, Thomas F., 87-0240M (4/87)
Simer, Frederick T., 85-0440M (8/87)
Simmons, Roy D., 86-0604M (7/87)
Simpson, John D., 86-0345M (3,3,4/87)
Sims, Marvin L., 84-0322M (5/87)
Sinnott, Harold, 87-0486M (8/87)
Skipper, Mary L., 87-0429M (8/87)
Sletager, Clarence H., 86-0418M (3/87)
Smail, Jeffery, 87-0300M (9/87)
Smith, Betty J., 86-0212M (3/87)
Smith, Edward G., 85-0352M (5/87)
Smith, Franklin E., 87-0335M (8/87)
Smith, Gorman R., 86-0018M (7/87)
Smith, Harvey F., 87-0183M (3/87)
Smith, James C., 87-0117M (3/87)
Smith, James L., 86-0596M (2/87)
Smith, Larry E., 87-0272M (5,5/87)
Smith, Lawrence E., 87-0412M (7/87)
Smith, Michael A., 86-0186M (3,5/87)
Smith, Miller A., 87-0092M (2,9/87)
Smith, Richard E., 85-0670M (4/87)
Smith, Thomas J., 87-0100M (6/87)
Smith, Willard, 87-0537M (9/87)
Smith, William F., 84-0353M (6/87)
Snyder, James F., 87-0398M (7/87)
Snyder, Melvin L., 87-0088M (3/87)
Sowell, Raymond L., 86-0365M (2/87)
Spence, Paul E., 87-0373M (8/87)
Spiering, Douglas J., 87-0281M (6/87)
Springs, Alberta M., 87-0125M (3,7/87)

Name, WCB Number (Month/Year)

St. John, Donald L., 85-0396M (5/87)
Stafford, Donna M., 86-0262M (8/87)
Steen, Maurice, 87-0490M (9/87)
Stephens, Fred R., 87-0433M (9/87)
Stevens, Weldon, 84-0395M (8/87)
Stewart, Craig L., 87-0421M (8/87)
Stone, Steven H., 87-0365M (9/87)
Stratton, Anita J., 84-0537M (3,6/87)
Stratton, Anna B., 86-0322M (4,5/87)
Stratton-Andersen, Judy, 87-0442M (9/87)
Strehlow-Holt, Roberta, 86-0540M (1/87)
Stroup, William M., 87-0063M (1/87)
Stuart, David, 87-0054M (2,7/87)
Sullivan, Leslie M., 86-0077M (9/87)
Sullivan, Richard T., 86-0643M (1,4/87)
Swenson, Deborah L., 87-0456M (9/87)
Taskinen, Toivo R., 87-0428M (8/87)
Tatum, Beverly J., 86-0202M (4/87)
Tawney, Theda, 87-0396M (7/87)
Taylor, Donald R., 84-0541M (2/87)
Taylor, Gene R., 85-0282M (2/87)
Taylor, Kathy L., 87-0061M (4,6/87)
Taylor, Lloyd L., 86-0693M (2/87)
Thain, Jerome E., 87-0042M (1/87)
Thiems, John C., 87-0464M (8/87)
Thomas, Candy, 87-0203M (8/87)
Thomas, Tom E., 86-0341M (2/87)
Thompson, Vivian K., 87-0275M (9/87)
Thompson, Warren G., 86-0245M (9/87)
Thornsberry, Raymond, 83-0083M (2,2/87)
Thrasher, Ronald W., 86-0696M (3/87)
Thrush, Barbara, 87-0542M (9/87)
Thurman, Donald, 87-0298M (5/87)
Tieman, Delbert, 87-0248M (5/87)
Todd, Samuel C., 87-0447M (8/87)
Toycen, John L., 86-0698M (2/87)
Travis, Pauline L., 86-0700M (7/87)
Truesdell, Robert, 87-0304M (6/87)
Turan, Carolyn, 82-0186M (9/87)
Turner, Cecil Jenetta, 87-0358M (7/87)
Tussing, Phillip N., 87-0040M (7/87)
Ulery, William R., 87-0106M (3/87)
Upton-Hurley, Susan, 87-0434M (9,9/87)
Urbano, Bernice, 86-0109M (8/87)
Valentine, Myron C., 87-0321M (6/87)
Valle, Salvador B., 87-0458M (9/87)
Van Cleve, Gary E., 87-0378M (9/87)
Vanlandingham, Coburn, 86-0463M (1/87)
Vatland, Milnor R., 86-0519M (3/87)
Vering, John, 84-0043M (3/87)
Vilches, Alfonso, 86-0526M (4/87)
Vinzant, Steven, 86-0274M (4/87)
Vohs, Roger L., 87-0035M (2/87)
Voshell, George O., 87-0108M (4/87)
Voss, Robert A., 86-0633M (2,5,9/87)
Waddy, Samuel, 84-0318M (6/87)
Wade, Walter F., 87-0407M (7/87)
Wade, William M., 86-0523M (8/87)
Waits, Joan L., 86-0702M (1/87)
Wallace, Larry L., 87-0226M (5/87)
Wallace, Robert W., 87-0247M (4/87)
Wallman, Lester, 87-0288M (6,7/87)
Walters, Edward, 87-0340M (8/87)
Warkentin, Jerry, 87-0127M (3/87)
Warner, Jim N., 87-0002M (1/87)
Warren, James R., 87-0296M (8/87)
Watson, Thomas, 87-0033M (2,3/87)
Waybrant, Thomas H., 87-0187M (3/87)
Weaver, Gregory W., 87-0197M (4/87)
Webb, Paula L., 86-0292M (3/87)
Weckerle, Joseph F., 81-0221M (2/87)
Weickum, Gary J., 87-0258M (8/87)
Weigel, Daniel W., 87-0104M (5/87)
Weiser, Yvonne, 87-0163M (5/87)
Weller, William, 87-0140M (4/87)
Welter, Stephen M., 84-0045M (6/87)
Werbin, Carl F., 87-0403M (7/87)
Werner, Diane A., 87-0036M (1,4/87)
Wheatley, Joyce M., 86-0328M (1/87)
White, James B., 84-0086M (6/87)
Whitely, Eugene C., 87-0306M (7/87)
Whitman, Cecil C., 85-0374M (5,6/87)
Wild, Karl J., 87-0411M (8/87)
Williams, Emma J., 85-0383M (7/87)
Williams, Stanley O., 87-0080M (7/87)
Willis, Cemmie L., 87-0332M (6,8/87)
Wilson, James H., 86-0360M (6,9/87)
Wilson, William H., 86-0639M (4,6/87)
Wilson, William H., 87-0068M (7/87)
Wilson, William J., 87-0508M (9/87)
Winger, Curtis T., 86-0612M (1/87)
Wittmeyer, Wayne L., 87-0022M (1/87)
Wood, William E., 87-0192M (4/87)
Woodruff, Ellanora, 87-0307M (6/87)
Wright, Donald C., 86-0572M (8/87)
Wright, Jack, 86-0430M (3/87)
Xistras, George, 87-0548M (9/87)
Yeaple, Clarence, 87-0250M (5/87)
Young, Cendrina M., 86-0709M (1,8/87)
Young, Thomas A., 86-0552M (2,3/87)
Yowell, Jay A., 87-0308M (6/87)
Zimmerman, Ronald L., 87-0260M (5/87)

CLAIMANT INDEX 1987

Claimant (WCB Number and/or Court Number)------page(s)

Claimant (WCB Number and/or Court Number)------page(s)

Claimant (WCB Number and/or Court Number)------page(s)

Claimant (WCB Number and/or Court Number)------page(s)

Claimant (WCB Number and/or Court Number)------page(s)

Claimant (WCB Number and/or Court Number)------page(s)

Claimant (WCB Number and/or Court Number)------page(s)

Claimant (WCB Number and/or Court Number)------page(s)

Claimant (WCB Number and/or Court Number)------page(s)