VAN NATTA'S WORKERS' COMPENSATION REPORTER

VOLUME 40

(Pages 1-324)

A compilation of the decisions of the Oregon Workers' Compensation Board and the opinions of the Oregon Supreme Court and Court of Appeals relating to workers' compensation law, and including Administrative Rules, effective January 1, 1988

JANUARY-MARCH 1988

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CITE AS

40 Van Natta ____ (1988)

ANDREA L. WARRINGTON, Applicant
Ann Kelley, Ass't. Attorney General

WCB CV-87008
December 2, 1988
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 June 1, 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 found that applicant and her assailant were "sharing the same household" at the time the crime was committed. Accordingly, relying on ORS 147.015(4), the Department concluded that applicant was not entitled to an award of compensation.

Following our receipt of the request for review, applicant was advised that she was entitled to a fact finding hearing before a Special Hearings Officer. To exercise her right to a hearing, applicant was instructed to so notify the Board within 15 days from the date the Department mailed her a copy of its record. The Department mailed a copy of its record to applicant on August 18, 1987. Having received no hearing request, we have conducted our review based solely on the written record. See OAR 438-82-030(2).

The standard for our review under the Act is de novo, based on the entire record. ORS 147.155(5); Jill M. Gabriel, 35 Van Natta 1224, 1226 (1983). Based on our de novo review of the record, we make the following findings.

Applicant is the innocent victim of the unprovoked crime of assault. She timely filed a claim for compensation, asserting that she had been assaulted by Kevin McDonough on August 30, 1986. The assault involved a violent series of chokings, beatings, and kickings about the head, neck, and abdomen, which eventually rendered applicant unconscious. Following out-patient emergency room treatment, her condition was diagnosed as "a rather severe sprain of the cervical and thoracic spine." In addition, she suffered a left knee laceration and had multiple areas of contusions, bruises and swelling over her entire body.

As a result of her injuries, applicant missed several days of work and, upon returning to her work activities as a cook, was forced to limit her normal duties for "some time." She has also required ongoing counseling and therapy to resolve her "Post Traumatic Stress Syndrome."

In lieu of $5,000 bail, McDonough was lodged in the county jail for attempted assault in the second degree. Sometime after his release, he left the state. Despite applicant's full cooperation with law enforcement authorities, no prosecution has been initiated.

According to applicant's claim for benefits, she and McDonough were sharing the same household at the time of the assault. The police report supports this statement, listing the same home address for both applicant and McDonough. The police report also identifies McDonough as applicant's "boyfriend."

On March 12, 1987, the Department issued its Findings of Fact, Conclusions and Order. Finding that applicant and her

assailant were "sharing the same household" at the time of the assault, the Department concluded that applicant was not entitled to compensation. Consequently, the claim was denied.

Thereafter, applicant requested reconsideration. She acknowledged that McDonough had been "temporarily staying" at her house, while he looked for work. However, she had advised him on several occasions to leave the residence and return to the mobile home he was purchasing outside of town. Applicant further stated that, for two weeks prior to the assault, McDonough's "few belongings" had been loaded in his truck. In addition, she had locked him out of the house, only to have him break back in. Asserting that McDonough had neither contributed monetarily nor physically, applicant contended that they had not shared the household.

Applicant's parents submitted a notarized statement in support of their daughter's request for reconsideration. The Warringtons conceded that McDonough had been staying at applicant's house for "a couple of months." However, they echoed applicant's statements that McDonough had not contributed to the household in any manner. Furthermore, whenever McDonough was told to leave, the Warringtons stated that he generally responded with "a threat." The night before the assault, McDonough had assured them that he would no longer be staying with applicant.

Peer English also submitted a notarized statement. English had known McDonough for some seven months prior to the assault. He acknowledged that McDonough had been staying with applicant for the "last two months" before the attack. However, English supported applicant's assertion that her repeated requests for McDonough to vacate the premises had resulted in threats of hostility. English further confirmed that McDonough had made no contribution to the household.

The Department issued an Order on Reconsideration on June 1, 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:

> "(4) The victim and the assailant of the victim were not related or sharing the same household;"

"Sharing the same household" means an assailant and victim are lodged in the same residence or domicile, whether said joint occupancy is by financial arrangement or invitation, and when said occupancy includes sleeping accomodations for one night or more. OAR 137-76-010(3).

On de novo review of this record, we are persuaded that applicant and her assailant were not "sharing the same household" at the time of the unprovoked assault. See ORS 147.015(4); OAR 137-76-010(3). Consequently, we conclude that the Department's denial of applicant's claim for compensation should be set aside.

The record suggests that McDonough neither contributed monetarily nor physically to the household during the approximately two month period they jointly occupied the residence. Yet, such support is not necessary, provided that the shared lodging and accomodations were by invitation. See OAR 137-76-010(3). Here, applicant and her witnesses concede that McDonough was "temporarily" staying at her home. However, they insist that this "invitation" was revoked several weeks prior to the assault. Our review of the evidence supports applicant's contention that McDonough's continued presence at the residence was contrary to her express wishes. Moreover, the record indicates that the assailant's presence was attributable to his threats to applicant's well-being. Thus, any "invitation" existing at the time of the unprovoked attack had been made under duress and would be considered invalid.

Inasmuch as McDonough's joint occupancy of applicant's residence was neither by financial arrangement nor by invitation, we conclude that applicant was not "sharing the same household" at the time of the assault. See ORS 147.015(4); OAR 137-76-010(3). Therefore, this statutory exclusion to a claim for benefits is not applicable. Since the claim meets the remaining statutory requirements for eligibility, we conclude that applicant is entitled to compensation. See ORS 147.015. Accordingly, the Department's Order on Reconsideration shall be reversed.

ORDER

The Findings of Fact, Conclusions and Order on Reconsideration of the Department of Justice Crime Victim Compensation Fund dated June 1, 1987 is reversed. The Department's denial is set aside and the claim for benefits is remanded to the Department for processing according to law.

MARCO AGUIAR, Claimant
Kenneth D. Peterson, Claimant's Attorney
Meyers & Terrall, Defense Attorneys

WCB 84-05596
January 7, 1988
Order on Remand

This matter is before the Board on remand from the Court of Appeals. Aguiar v. J.R. Simplot Company, 87 Or App 475 (1987). We have been instructed to reinstate the Referee's order that set aside the self-insured employer's partial denial of claimant's proposed right foot surgery and awarded attorney fees. Furthermore, concluding that the claim was prematurely closed, the court has directed that the May 15, 1984 Determination Order be rescinded.

Pursuant to the court's mandate, the Referee's order is reinstated insofar as it set aside the employer's September 10, 1984 partial denial and awarded a reasonable employer-paid attorney fee of $1,200. In addition, the May 15, 1984 Determination Order is rescinded as premature. Accordingly, this claim is remanded to the self-insured employer for processing according to law.

IT IS SO ORDERED.

CHARLOTTE J. DAZA, Claimant
Malagon & Moore, Claimant's Attorneys
SAIF Corp Legal, Defense Attorney

WCB 86-10179
January 7, 1988
Order on Review (Remanding)

Reviewed by Board Members Johnson and Crider.

Claimant requests review of Referee Nichols' order that affirmed an award by Determination Order of 20 percent (64 degrees) unscheduled permanent partial disability for a low back injury. On review, the issue is extent of unscheduled permanent disability.

Following our de novo review of the record, we note that the Referee admitted into evidence Exhibit 22. The parties' briefs refer to this exhibit as a March 24, 1987 report from Dr. Walborn, claimant's treating physician. However, the record on review neither contains an Exhibit 22 nor any report from Dr. Walborn dated March 24, 1987.

Pursuant to ORS 656.295(5), we may remand to the Referee for further evidence taking, correction or other necessary action when we determine that a case has been improperly, incompletely, or otherwise insufficiently developed. We conclude that the omission of Exhibit 22 constitutes an improper, incomplete, or otherwise insufficient development of this case.

Accordingly, we remand to the Referee to reconsider this matter in light of our discovery. Should the Referee conclude that a hearing is necessary to identify the aforementioned exhibit and include it in the record, she is directed to initiate the appropriate proceedings. The Referee is further directed to issue an order on remand indicating the effect, if any, the report's inclusion into the record has upon her original order.

ORDER

This case is remanded to the Referee for further action consistent with this order.

ELSIE L. HOBKIRK, Claimant
Roberts, et al., Claimant's Attorneys
SAIF Corp Legal, Defense Attorney

WCB 87-04327
January 7, 1988
Order of Dismissal (Remanding)

The SAIF Corporation has requested Board review of Referee Wasley's October 21, 1987 order. On November 19, 1987, SAIF timely mailed its request for Board review. See ORS 656.289(3); OAR 438-11-005(2); 438-05-040(4). That same day, Referee Wasley issued an Order of Abatement to consider SAIF's Motion for Reconsideration.

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

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

IT IS SO ORDERED.

GEORGE R. OLEACHEA, Claimant
Michael Bruce, Claimant's Attorney
Schwabe, et al., Defense Attorneys

WCB 85-05633
January 7, 1988
Order on Review

Reviewed by Board Members Johnson and Crider.

Claimant requests review of those portions of Referee Brown's order that: (1) reversed a July 30, 1986 Determination Order award of 15 percent (48 degrees) unscheduled permanent disability for a low back injury; and (2) granted the self-insured employer authorization to recover temporary disability benefits paid after termination of an authorized training program, but before the issuance of a Determination Order. The issues are extent and offset.

The Board affirms the order of the Referee with the following comment concerning the offset issue.

After completion of claimant's authorized training program, the employer properly continued to pay temporary disability benefits pending a subsequent Determination Order by the Evaluation Division. See ORS 656.268(2), and (5); OAR 436-60-040(3). Upon closure of the claim, the employer is entitled to recover these benefits which were paid to a medically stationary worker while he was not enrolled and actively engaged in training. See ORS 656.268(4); OAR 436-120-230(4).

ORDER

The Referee's order dated April 8, 1987 is affirmed, as supplemented.

JOSE YBARRA, Claimant
Francesconi & Cash, Claimant's Attorneys
Rankin, et al., Defense Attorneys

WCB 86-08841
January 7, 1988
Order on Review

Reviewed by Board Members Ferris and Johnson.

The self-insured employer requests review of Referee Quillinan's order that: (1) set aside its denial of claimant's aggravation claim for a low back condition; and (2) set aside its denial of ongoing chiropractic treatments for the same condition. The issues are aggravation and medical services.

Claimant was compensably injured in 1981 while picking mushrooms. Surgery, in the form of a laminotomy at L4-5 with partial excision of the disc, was performed. Claimant has not returned to work of any kind since the time of the injury. As of September 19, 1983, the date of his last award of compensation, claimant has received a total of 60 percent (192 degrees) unscheduled permanent disability.

Following his 1983 award, claimant did not seek treatment for approximately one year. He testified that he would have sought treatment if he had realized that he was entitled to continuing medical services. When he subsequently learned that he was entitled to medical services, he began treating with Dr. Freeman, chiropractor. He later transferred his treatment to Dr. Anderson, chiropractor.

Dr. Anderson supports claimant's position that he has suffered an aggravation of his 1981 injury. He refers to claimant's present condition as a "natural aggravation." He bases his opinion

upon the following: reported neurological changes of hyporeflexia of the left patellar and plantar responses, apparent circumferential changes in the left calf and thigh versus the right, and increased ambulatory difficulties.

Countering the opinion of Dr. Anderson is that of Dr. Rosenbaum, neurosurgeon. Dr. Rosenbaum first examined claimant in June 1982. He reexamined claimant in November 1986. Based upon his examinations and his review of the medical records, Dr. Rosenbaum concludes that there have been no changes in claimant's symptoms or physical examination during the intervening years. His medical findings are similar in both reports.

Claimant was referred by Dr. Anderson to Dr. Goe, neurophysiologist and chiropractor, in the summer of 1986. Following an examination and review of claimant's medical record, Dr. Goe indicated agreement with Dr. Rosenbaum's report.

Claimant testified that his condition was worse than it had been at the time of his 1983 hearing. When questioned as to specifics, however, claimant testified that he was experiencing the same symptoms as he had at the time of his prior hearing. These symptoms included throbbing of his back and left leg as well as tremors. In addition, he repeatedly testified that he had experienced constant pain during the period between his hearings. He described this pain as the same he was experiencing at the time of his prior hearing.

The Referee found claimant, who testified through an interpreter, to be credible. Relying upon the opinion of the treating physician, the Referee found that claimant's condition had worsened. Consequently, the employer's denial was set aside. We disagree.

In order to prevail on his aggravation claim, claimant must prove that his underlying condition or his symptoms have worsened since the last award or arrangement of compensation so that he has suffered an additional loss of earning capacity. Smith v. SAIF, 302 Or 396 (1986). We are not persuaded that claimant's condition or symptoms have worsened since the last award of compensation.

Dr. Anderson opined that claimant had suffered an aggravation. Dr. Rosenbaum opined that he had not. Ordinarily, more weight will be given to the opinion of the treating physician. See, e.g. Weiland v. SAIF, 64 Or App 810 (1983). However, the persuasiveness of medical opinions in circumstances as are presented here depends to a significant degree upon the timing of the underlying examinations. See, e.g. Kienow's Food Stores v. Lyster, 79 Or App 416 (1986).

Claimant did not begin treating with Dr. Anderson until November 1985, more than two years following his last arrangement of compensation. Dr. Rosenbaum, on the other hand, examined claimant both before his prior hearing and subsequent to his claim for aggravation. Because of this advantage, we place more weight on Dr. Rosenbaum's opinion that claimant's symptoms and physical examination have remained unchanged since the last award of compensation. See Faye L. Ballweber, 36 Van Natta 303 (1984).

We are also influenced by claimant's own testimony regarding his unchanged symptoms. Finally, even if we were to accept Dr. Anderson's specific findings over those of Dr. Rosenbaum, we are

not persuaded that the physical changes noted by Dr. Anderson are suggestive of any additional loss of earning capacity. Accordingly, we reverse the Referee on the issue of aggravation.

The second issue which we must address involves claimant's entitlement to medical services.

At the time of hearing, claimant was receiving chiropractic treatment from Dr. Anderson on a weekly basis. Dr. Anderson considered the treatments reasonable and necessary, reporting "material improvement" in claimant's condition since initiation of treatments. Claimant testified that these treatments provided him shor term relief lasting from two to twelve hours.

Dr. Rosenbaum concluded that further treatments were not reasonable or necessary. After examining claimant and reviewing the medical record, Dr. Goe indicated his agreement with Dr. Rosenbaum's report. Dr. Goe further opined that the only additional treatment claimant required was stabilization of his sacroiliac joints by use of a trochanter belt and specific trigger point therapy. He expressly stated that the maximum effectiveness of such therapy is typically achieved within a few weeks.

On de novo review, we find that the record does not support Dr. Anderson's assertion that claimant has experienced material improvement as the result of his treatments. Rather, the record suggests transitory relief of claimant's symptoms, at best. We, therefore, conclude that claimant's chiropractic treatments are palliative, not curative.

Medical expenses for purely palliative purposes are recoverable where they are necessarily and reasonably incurred in the treatment of an injury. Wetzel v. Goodwin Brothers, 50 Or App 101, 108 (1981). When palliative treatments reduce a claimant's pain and enable him to work they are considered reasonable and necessary. West v. SAIF, 74 Or App 317, 321 (1985). However, considering claimant's continuing state of unemployment, the treatments here have not enabled him to work. Further, so far as the record discloses, claimant undergoes treatment on a scheduled basis rather than an "as needed" basis.

Claimant has the burden of proving the reasonableness and necessity of the chiropractic treatments. See, e.g. SAIF v. Belcher, 71 Or App 502 (1984). In light of the above considerations, and after reviewing the medical and lay evidence, we are not persuaded that claimant's treatments are necessary. The only medical evidence in support of treatment comes from the chiropractor who is providing it. We have rejected the reasoning supporting that opinion. Two other physicians, including a consulting chiropractor, have opined that the current treatments are not necessary. The medical evidence weighs against a finding of necessity.

We conclude that claimant's current chiropractic treatments are not reasonable or necessary in relation to his 1981 injury. The insurer's denial was couched in terms of a denial of "ongoing" treatments. We interpret such denials narrowly and not as applying to all future treatments. See Michael D. Flannery, 39 Van Natta 723 (1987). Thus, we express no opinion as to whether subsequent chiropractic treatments might be reasonable and necessary.

ORDER

The Referee's order dated April 6, 1987 is reversed. The self-insured employer's denial of February 6, 1987 relating to an aggravation claim and medical services is reinstated and upheld.

LINDA S. BEAMAN, Claimant
Brian R. Whitehead, Claimant's Attorney
Merrily McCabe (SAIF), Defense Attorney

WCB 86-06892
January 8, 1988
Order on Review

Reviewed by Board Members Crider and Johnson.

Claimant requests review of those portions of Referee Quillinan's order that: (1) declined to set aside a Determination Order as premature; (2) upheld the SAIF Corporation's denial of claimant's aggravation claim for a back condition; and (3) upheld SAIF's denial of medical services for claimant's current back condition. SAIF cross-requests review of that portion of the Referee's order that declined to rate the extent of claimant's unscheduled permanent disability. The issues are premature claim closure, aggravation, medical services, and whether the Referee was correct in declining to rate extent of disability.

Claimant, 35 at the hearing, compensably injured her low back in May 1985, while employed as a psychiatric aide. Shortly thereafter, she was examined by Dr. Wilson, chiropractor. Wilson took lumbar x-rays and released claimant to modified work. SAIF accepted the claim as a nondisabling injury.

Claimant worked without difficulty until August 1985, when she began to experience increased low back pain. She was taken off work by Dr. Wilson and underwent a CT scan, which revealed a slight posterior bulge at L4-5. In October 1985, she was examined by Dr. Buza, neurologist. Buza recommended that claimant try a TNS unit for a few weeks and then attempt to return to work.

Apparently worried that she would lose her job, claimant demanded a work release from Dr. Wilson. Although Wilson released her to regular work on October 29, 1985, he stated:

> "[Claimant] * * * indicated that her employer was going to be needing her on the first [sic] and she would like to return to work and yet her physical condition, upon presentation in this office does not warrant a full release."

The following day, Dr. Buza released claimant to light duty work effective November 4, 1985. In so doing, Buza stated:

> "[Claimant] still does have pain in her buttocks area both right and left. Still has difficulty twisting and turning, especially when she does so quickly. * * * She has been allowed to return to light duty beginning November 4, 1985 lifting no more that 10-20 lbs. and avoiding bending and twisting. She returns in a month. Perhaps she may be able to return back to full time duty thereafter but for the time

being it is only light duty, hopefully, for the next few months. This is not a closing exam."

In a Supplemental Medical Report form dated November 5, 1985, Buza stated that claimant was not medically stationary. Later that month, Buza released claimant to regular work.

On January 29, 1986, SAIF informed claimant that it would "assume" she was medically stationary in two weeks, unless it received further medical information concerning her condition. After receiving no further medical information, SAIF requested the Evaluation Division to close claimant's claim. In February 1986, a Determination Order issued awarding temporary disability only.

The following month, claimant injured her neck and back in a non-industrial automobile accident. As a result, she suffered increased low back pain. In May 1986, SAIF denied both an aggravation and further medical services on the basis that claimant's alleged worsening or current condition was "the result of an intervening automobile accident."

In February 1987, Dr. Wilson testified, by way of deposition, inter alia:

"Q. [SAIF ATTORNEY] And what was the effect of the automobile accident on [claimant's] back?"

"A. [DR. WILSON] Her main concern was the upper back and neck, and after a short course of treatment to the low back on the auto [accident], which appears to be reflected here in the chart notes, we moved her back over to the industrial injury because not only did she tell us that she felt her back [pain] was where it was just prior to the accident, but we felt that that was probably accurate and that there wasn't any significant aggravation as a result of the auto [accident]. So we felt most of her ongoing probems at that point in time were industrially related, not auto related." (Emphasis added).

The Referee found that: (1) the February 1986 Determination Order was not premature; and (2) that claimant's current need for medical treatment was not materially related to her compensable May 1985 back injury. We disagree.

First, we address the premature claim closure issue. ORS 656.268 provides, inter alia:

"(2) When the injured worker's condition resulting from a disabling injury has become medically stationary * * * the insurer or self-insured employer shall so notify the Evaluation Division, the worker, and the employer, if any, and request the claim be examined and further compensation, if any, be determined."

"(3) 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." (Emphasis added).

Here, SAIF accepted claimant's claim as a nondisabling injury. Therefore, at the appropriate time, SAIF could have processed the claim to closure by issuing a Notice of Closure pursuant to ORS 656.268(3). See Webb v. SAIF, 83 Or App 386, 390 (1987). Instead, SAIF utilized the process under ORS 656.268(2), and requested a Determination Order by the Evaluation Division. Under either statute, however, claimant's condition had to become medically stationary prior to claim closure. See ORS 656.268(1).

Neither Dr. Wilson, Dr. Buza, nor any other physician declared claimant medically stationary prior to the issuance of the February 1986 Determination Order. Although Wilson and Buza reluctantly released claimant to regular work in October 1985, their chart notes indicate that claimant's condition was, in fact, not medically stationary. Accordingly, after our de novo review, we find that claimant has proven by a preponderance of the evidence that the February 1986 Determination Order prematurely closed her claim.

Having set aside the Determination Order as premature, we need not address the issues of aggravation and whether the Referee erred in declining to rate claimant's extent of disability. That is, by way of this order, claimant's claim remained open at the time of the hearing.

Last, we address the medical services issue. When a claimant sustains a compensable injury, she is entitled to ongoing medical treatment "for conditions resulting from the injury for such a period as the nature of the injury or the process of recovery requires * * *. ORS 656.245(1). Further, a compensable injury need not be the sole cause of a claimant's continuing need for medical treatment; but rather, only a material contributing cause. See Aquillon v. CNA Insurance Co., 60 Or App 231, 236 (1982).

Here, no physician opined that claimant's current need for treatment was no longer related to her compensable May 1985 back injury. To the contrary, Dr. Wilson testified that most of claimant's ongoing problems were related to her industrial injury. Accordingly, we conclude that claimant has proven continued entitlement to medical services relating to her compensable May 1985 back injury.

ORDER

The Referee's order dated March 26, 1987 is reversed. The February 1986 Determination Order is set aside and the claim is remanded to the SAIF Corporation for processing according to law. Claimant's attorney is allowed 25 percent of the increased

compensation resulting from this order through the time of claim closure pursuant to ORS 656.268, not to exceed $3,000. In addition, claimant's attorney is awarded a reasonable attorney fee of $700 for services at hearing and $500 for services on Board review, to be paid by the SAIF Corporation.

THOMAS E. BISHOP, Claimant
Emmons, Kyle, et al., Claimant's Attorneys
Cummins, Cummins, et al., Defense Attorneys

WCB 85-05791
January 8, 1988
Order on Review

Reviewed by Board Members Johnson and Crider.

The self-insured employer requests review of Referee McCullough's order that set aside its denial of medical services relating to claimant's low back. The issue is medical services.

Claimant compensably injured his low back in August 1983 in the course of his employment as a sanitation worker at a cannery. He sought care from Dr. Clibborn, a chiropractor, who diagnosed a lumbosacral strain and began administering chiropractic treatments at a rate of three per week. In September 1983, an independent medical examination was performed by a panel of the Independent Chiropractic Consultants. The panel found no evidence of pathology or impairment and recommended claim closure. The claim was closed by Determination Order in February 1984 with no award of permanent disability.

Dr. Clibborn continued to treat claimant after claim closure at a rate of twice per week. An IME was performed by Dr. Kelley, a chiropractor, in November 1984. Dr. Kelley found no evidence of pathology or impairment and opined that no further curative or palliative treatment was reasonable or necessary for the industrial injury. Dr. Clibborn voiced his agreement with most of Dr. Kelley's report, but indicated that claimant needed ongoing palliative treatment due to his chronic pain. The employer issued a denial of further chiropractic treatment in March 1985 as not causally related to the industrial injury or reasonable and necessary. The following month, the Independent Chiropractic Consultants reexamined claimant. They found no evidence of pathology or impairment and opined that further palliative treatment was not reasonable or necessary.

In December 1985, Dr. Clibborn issued a conclusory, two-paragraph opinion in which he stated that claimant continued to experience periodic bouts of low back pain which were related to the industrial injury and which required palliative care. Another IME was conducted by Dr. Spady, an orthopedic surgeon, in July 1986. Dr. Spady found no evidence of pathology or impairment and stated that the ongoing chiropractic treatment was not related to the effects of the industrial injury.

At the hearing, claimant testified that he continued to experience periodic pain in his back and that Dr. Clibborn's treatment helped relieve this pain for a few days. He indicated that he had not seen Dr. Clibborn for about a month prior to the hearing and that he continued to perform his regular work. He also indicated that his treatment schedule had been dictated by Dr. Clibborn and was not just on an as needed basis.

Citing Dr. Clibborn's reports and claimant's testimony, the Referee concluded that claimant's treatments were reasonable, necessary and causally related to the industrial injury and set aside the employer's denial. We disagree and conclude, based upon the

preponderance of the evidence, that claimant's course of treatment has not been reasonable or necessary. We reverse the Referee's order on that ground. ORS 656.245.

ORDER

The Referee's order dated January 29, 1987, as supplemented by the Order on Reconsideration dated April 2, 1987, is reversed. The self-insured employer's denial dated March 18, 1985 is reinstated and affirmed.

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

WCB 86-10546
January 8, 1988
Order Denying Reconsideration

Claimant has requested reconsideration of the Board's October 13, 1987 Order of Dismissal. The request is denied.

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

Inasmuch as the Board's October 13, 1987 order has neither been appealed, abated, "stayed," nor republished, it has become final by operation of law. Consequently, the Board lacks jurisdiction to consider claimant's request.

IT IS SO ORDERED.

LILLIE A. PICTHALL, Claimant
Kirkpatrick & Zeitz, Claimant's Attorneys
SAIF Corp Legal, Defense Attorney

WCB 86-07342
January 8, 1988
Order of Dismissal

On December 24, 1987, claimant requested Board review of Referee Norr's November 18, 1987 order. Inasmuch as the request was filed more than 30 days from the date copies of the Referee's order were mailed to the parties, the order has become final. See ORS 656.289(3). Accordingly, the request for Board review is dismissed as untimely.

IT IS SO ORDERED.

ROBERT L. AKERSON, Claimant
Malagon & Moore, Claimant's Attorneys
Roberts, et al., Defense Attorneys

WCB 85-14555 & 86-11545
January 12, 1988
Order on Review

Reviewed by Board Members Crider and Ferris.

Claimant requests review of Referee Myers' order that upheld the insurer's denial of his claim for physical and psychological effects of exposure to pesticides. If the Board overturns the insurer's denial, claimant requests that his attorney be granted an extraordinary attorney fee. The issues are compensability and attorney fees.

Claimant began working for the employer, a wholesale

nursery, in early 1983. He worked primarily as a sales and delivery person. This involved making phone and personal contacts with clients, pulling orders, cleaning plants and delivering the plants to the clients. Claimant often had to work in the employer's greenhouses while plants were being sprayed with pesticides and he sometimes had to handle plants which were wet with spray.

During the spring of 1985, insect pests began to multiply and a number of plants also became infected with a disease called Pseudomonas. Claimant's coworkers began spraying the plants with a variety of organophosphate and carbamate chemicals in an attempt to eradicate the pests and control the disease. In addition, on at least one occasion, the employer applied organophosphates through the nursery's fertilization system.

Early in the summer of 1985, claimant began to experience symptoms which included skin rashes, shortness of breath, nausea, abdominal cramps, diarrhea, lethargy, forgetfulness, mood swings, headaches, blurred vision, muscle tremors and excessive perspiration. By the end of July, several of claimant's coworkers were complaining of similar symptoms and health officials inspected the employer's premises. The employer was cited for a number of violations which exposed workers to increased risk of pesticide contamination.

Claimant filed a workers' compensation claim on August 2, 1985 and sought treatment from Dr. Redfield, a specialist in occupational medicine. Claimant left work and his symptoms began to improve. Blood and urine tests taken about that time failed to reveal any chemical residue in claimant's body. Dr. Redfield diagnosed apparent exposure to organophosphate and other pesticides, with residual symptoms.

In mid-August, claimant and a number of coworkers were referred to Dr. Leveque, an osteopath with expertise in toxicology. After that, claimant and his coworkers met with Dr. Leveque about once per week for a number of months. During these meetings, claimant and his coworkers discussed their symptoms. Dr. Leveque prescribed some medications, but otherwise rendered no active treatment.

Based upon claimant's subjective complaints, Dr. Leveque concluded that claimant had been severely poisoned by pesticides and referred him to Dr. Kurlychek, a neuropsychologist. Dr. Kurlychek administered a number of tests and interpreted them to show disruption of cognitive abilities and motor coordination. He concluded that these problems were related to claimant's exposure to pesticides at work and anticipated that the problems would continue for up to a year as the chemical residues slowly dissipated from claimant's body.

In November 1985, claimant was examined by Dr. Bardana, the Head of the Allergy and Clinical Immunology Division of the Oregon Health Sciences University. At the time of the examination, claimant complained of continued problems with shortness of breath, mood swings, headaches, diarrhea and excessive sweating. From the history recited by claimant regarding his work activities and subsequent symptoms, Dr. Bardana diagnosed doubtful acute, transient carbamate/organophosphate intoxication. He did not think that claimant's ongoing symptoms were due to chemical exposure because, according to Dr. Bardana, the pesticides to which claimant allegedly was exposed decompose into harmless chemicals within a few days. Instead, he attributed claimant's ongoing symptoms to preexisting medical problems and psychological factors. Similar conclusions were later expressed by Dr. Bayer, the Director of the Poison Center of the Oregon Health Sciences University.

In December 1985, the insurer issued a denial of the compensability of claimant's complaints on the ground that the complaints did not arise out of and in the course of his employment.

Claimant was examined by Dr. Holland, a psychiatrist, in March 1986. After obtaining a detailed history and administering a number of tests, Dr. Holland diagnosed atypical somatoform disorder secondary to a belief induced by his doctors that he had been damaged by pesticide exposure.

At the hearing, claimant testified that he continued to experience difficulty with decreased manual dexterity and excessive sweating. Dr. Leveque testified that, in his opinion, claimant had been exposed to pesticides in sufficient quantities to cause physical effects and that claimant in fact continued to experience physical effects from the exposure. Drs. Bardana and Holland also testified and, with some elaboration, reiterated their previous opinions.

The Referee concluded that claimant had failed to prove that he continued to experience any physical effects from pesticide exposure. Instead, he found that claimant's ongoing complaints were psychological in origin. Regarding the compensability of the psychological condition, the Referee concluded that the condition had been induced by Dr. Leveque's course of treatment, which had reinforced claimant's belief that he had been severely injured by exposure to pesticides. The Referee then concluded that Dr. Leveque's course of treatment was not reasonable and necessary, ostensibly because it was based upon a misdiagnosis of claimant's condition and was ineffective, and ruled claimant's psychological condition not compensable for that reason.

We agree with the Referee that claimant does not currently experience any physical effects from his chemical exposure. We do find, however, that claimant was exposed to toxic concentrations of pesticides and did experience transient symptoms as a result. We also find that the psychological condition identified by Dr. Holland (atypical somatoform disorder) is compensable. The transient symptoms which claimant experienced as a result of his exposure to pesticides required medical treatment and thus represented a compensable occupational disease. See Collins v. Hygenic Corp., 86 Or App 484 (1987). Claimant, in good faith, sought treatment for that disease. The fact that Dr. Leveque may have misdiagnosed claimant's condition and rendered treatment that was unnecessary and even harmful as a result of this misdiagnosis does not render the harmful consequences of the treatment noncompensable. 1 Larson, The Law of Workmen's Compensation §13.21, at 3-415 (1985); cf. Williams v. Gates, McDonald & Co., 300 Or 278, 281-82 (1985). We, therefore, set aside the insurer's denial and remand the claim to the insurer for processing.

Regarding the attorney fee issue, claimant's attorney has indicated that upon request he would provide a statement setting forth his services in this case. Claimant's attorney should submit such a statement with a motion for reconsideration if he is not satisfied with the attorney fee awarded below.

ORDER

The Referee's order dated February 26, 1987 is reversed. The insurer's denial dated December 19, 1985 is set aside and the claim is remanded to the insurer for processing according to law. Claimant's attorney is awarded $1,000 for services at the hearing and $400 for services on Board review, to be paid by the insurer.

EARL M. BROWN, Claimant
Malagon & Moore, Claimant's Attorneys
Roberts, et al., Defense Attorneys

WCB 86-00251
January 12, 1988
Order on Review

Reviewed by Board Members Crider and Ferris.

Claimant requests review of Referee Myers' order that upheld the insurer's denial of his claim for physical and psychological effects of exposure to pesticides. If the Board overturns the insurer's denial, claimant requests that his attorney be granted an extraordinary attorney fee. The issues are compensability and attorney fees.

Claimant began working for the employer, a wholesale nursery, in late 1984. He worked initially as a greenhouse laborer and then later was promoted to greenhouse manager. His duties included potting and repotting plants, plant propagation, moving plants between greenhouses and application of pesticides.

During the spring of 1985, insect pests began to multiply and a number of plants also became infected with a disease called Pseudomonas. Claimant and his coworkers began spraying the plants with a variety of organophosphate and carbamate chemicals in an attempt to eradicate the pests and control the disease. In addition, on at least one occasion, the employer applied organophosphates through the nursery's fertilization system.

Early in the summer of 1985, claimant began to experience symptoms which included skin rashes, shortness of breath, nausea, abdominal cramps, diarrhea, lethargy, forgetfulness, mood swings, headaches, blurred vision, muscle tremors and excessive perspiration. By the end of July, several of claimant's coworkers were complaining of similar symptoms and health officials inspected the employer's premises. The employer was cited for a number of violations which exposed workers to increased risk of pesticide contamination.

Claimant filed a workers' compensation claim on August 2, 1985 and sought treatment from Dr. Redfield, a specialist in occupational medicine. Claimant left work and his symptoms began to improve. Blood and urine tests taken about that time failed to reveal any chemical residue in claimant's body. They were suggestive of liver dysfunction, however. Dr. Redfield diagnosed apparent exposure to organophosphate and other pesticides, with residual symptoms.

In mid-August, claimant and a number of coworkers were referred to Dr. Leveque, an osteopath with expertise in toxicology. After that, claimant and his coworkers met with Dr. Leveque about once per week for a number of months. During these meetings, claimant and his coworkers discussed their symptoms. Dr. Leveque prescribed some medications, but otherwise rendered no active treatment.

Based upon claimant's subjective complaints, Dr. Leveque concluded that claimant had been severely poisoned by pesticides and referred him to Dr. Kurlychek, a neuropsychologist. Dr. Kurlychek administered a number of tests and interpreted them to show disruption of "visual-motor integration" and impairment of attention and concentration abilities. He concluded that these problems were related to claimant's exposure to pesticides at work and anticipated that the problems would continue for up to a year as the chemical residues slowly dissipated from claimant's body.

In November 1985, claimant was examined by Dr. Bardana, the

Head of the Allergy and Clinical Immunology Division of the Oregon Health Sciences University. At the time of the examination, claimant complained of continued problems with forgetfulness, mood swings and night sweats. From the history recited by claimant, which Dr. Bardana found selective and inconsistent, Dr. Bardana diagnosed doubtful acute, transient carbamate/organophosphate intoxication. In any event, he did not think that claimant's ongoing symptoms were due to chemical exposure because, according to Dr. Bardana, the pesticides to which claimant allegedly was exposed decompose into harmless chemicals within a few days. Instead, he attributed claimant's ongoing symptoms to preexisting allergic tendencies, bronchial hyperreactivity and psychological factors. Similar conclusions were later expressed by Dr. Bayer, the Director of the Poison Center of the Oregon Health Sciences University.

In December 1985, the insurer issued a denial of the compensability of claimant's complaints on the ground that the complaints did not arise out of and in the course of his employment.

Claimant was examined by Dr. Holland, a psychiatrist, in March 1986. After obtaining a detailed history and administering a number of tests, Dr. Holland diagnosed an adjustment disorder with mixed emotional features, secondary to a belief induced by his doctors that he had been damaged by pesticide exposure.

At the hearing, claimant testified that he continued to experience difficulty with muscle tremors and anxiety. Dr. Leveque testified that, in his opinion, claimant had been exposed to pesticides in sufficient quantities to cause physical effects and that claimant in fact continued to experience physical effects from the exposure. Drs. Bardana and Holland also testified and, with some elaboration, reiterated their previous opinions.

The Referee concluded that claimant had failed to prove that he continued to experience any physical effects from pesticide exposure. Instead, he found that claimant's ongoing complaints were psychological in origin. Regarding the compensability of the psychological condition, the Referee concluded that the condition had been induced by Dr. Leveque's course of treatment, which had reinforced claimant's belief that he had been severely injured by exposure to pesticides. The Referee then concluded that Dr. Leveque's course of treatment was not reasonable and necessary, ostensibly because it was based upon a misdiagnosis of claimant's condition and was ineffective, and ruled claimant's psychological condition not compensable for that reason.

We agree with the Referee that claimant does not currently experience any physical effects from his chemical exposure. We do find, however, that claimant was exposed to toxic concentrations of pesticides and did experience transient symptoms as a result. We also find that the psychological condition identified by Dr. Holland (adjustment disorder with mixed emotional features) is compensable. The transient symptoms which claimant experienced as a result of his exposure to pesticides required medical treatment and thus represented a compensable occupational disease. See Collins v. Hygenic Corp., 86 Or App 484 (1987). Claimant sought medical treatment for this disease in good faith. The fact that Dr. Leveque may have misdiagnosed claimant's condition and rendered treatment that was unnecessary and even harmful as a result of this misdiagnosis does not render the harmful consequences of the treatment noncompensable. 1 Larson, The

Law of Workmen's Compensation §13.21, at 3-415 (1985); cf. Williams v. Gates, McDonald & Co., 300 Or 278, 281-82 (1985). We, therefore, set aside the insurer's denial and remand the claim to the insurer for processing.

Regarding the attorney fee issue, claimant's attorney has indicated that upon request he would provide a statement setting forth his services in this case. Claimant's attorney should submit such a statement with a motion for reconsideration if he is not satisfied with the attorney fee awarded below.

ORDER

The Referee's order dated February 26, 1987 is reversed. The insurer's denial dated December 19, 1985 is set aside and the claim is remanded to the insurer for processing according to law. Claimant's attorney is awarded $1,000 for services at the hearing and $400 for services on Board review, to be paid by the insurer.

TERRY L. LINK, Claimant
Malagon & Moore, Claimant's Attorneys
Roberts, et al., Defense Attorneys

WCB 86-01751
January 12, 1988
Order on Review

Reviewed by Board Members Ferris and Crider.

Claimant requests review of Referee Myers' order that upheld the insurer's partial denial relating to a psychological condition. If the Board overturns the insurer's denial, claimant requests that his attorney be granted an extraordinary attorney fee. The issues are compensability and attorney fees.

Claimant began working for the employer, a wholesale nursery, in March 1985. For several weeks, he performed miscellaneous chores which included cleaning, watering, pruning and repotting various plants. After that, one of claimant's coworkers whose primary duty was to apply pesticides left the employer and claimant took over his position. In this position, claimant spent several hours two or three times per week spraying pesticides in the employer's various greenhouses. He wore protective clothing over most of his body, but it was tattered in places and leaked.

In May and June 1985, insect pests began to multiply and a number of plants also became infected with a disease called Pseudomonas. Claimant began spraying the plants with a variety of organophosphate and carbamate chemicals in an attempt to eradicate the pests and control the disease. In addition, on at least one occasion, the employer applied organophosphates through the nursery's fertilization system.

During June, claimant began to notice a rash on his hands and feet. Over the next few weeks he experienced other symptoms which included shortness of breath, lethargy, forgetfulness, mood swings, nausea, abdominal cramps, headaches, blurred vision, muscle tremors and excessive perspiration. By the end of July, several of claimant's coworkers were complaining of similar symptoms and health officials inspected the employer's premises. The employer was cited for a number of violations which exposed workers to increased risk of pesticide contamination.

Claimant filed a workers' compensation claim on August 2, 1985 and sought treatment from Dr. Church, a family practitioner, and Dr. Redfield, a specialist in occupational medicine. Claimant left work and his symptoms began to improve. Blood and urine tests taken about that time failed to reveal any chemical residue in claimant's body, but a respiratory test showed decreased lung function. Dr. Redfield diagnosed apparent exposure to organophosphate and other pesticides, with residual symptoms.

In mid-August, claimant and a number of coworkers were referred to Dr. Leveque, an osteopath with expertise in toxicology. After that, claimant and his coworkers met with Dr. Leveque about once per week for a number of months. During these meetings, claimant and his coworkers discussed their symptoms. Dr. Leveque prescribed some medications, but otherwise rendered no active treatment.

Based upon claimant's subjective complaints, Dr. Leveque concluded that claimant had been severely poisoned by pesticides and referred him to Dr. Kurlychek, a neuropsychologist. Dr. Kurlychek administered a number of tests and interpreted them to show disruption of cognitive abilities and impairment of coordination. He concluded that these problems were related to claimant's exposure to pesticides at work and anticipated that the problems would continue for up to a year as the chemical residues slowly dissipated from claimant's body.

In November 1985, claimant was examined by Dr. Bardana, the Head of the Allergy and Clinical Immunology Division of the Oregon Health Sciences University. At the time of the examination, claimant complained of continued problems with shortness of breath, lethargy, forgetfulness and mood swings. From the history recited by claimant regarding his work activities and subsequent symptoms, Dr. Bardana diagnosed probable acute, transient carbamate/organophosphate intoxication. He did not think, however, that claimant's ongoing symptoms were due to chemical exposure because, according to Dr. Bardana, the pesticides to which claimant was exposed decompose into harmless chemicals within a few days. Instead, he attributed claimant's ongoing symptoms to preexisting allergic and asthmatic tendencies and psychological factors. These conclusions were later echoed by Dr. Bayer, the Director of the Poison Center of the Oregon Health Sciences University.

In Janaury 1986, the insurer notified claimant that it was accepting his claim for "acute, transient carbamate/organophosphate intoxication." It deferred acceptance or denial of any psychological condition pending an examination by Dr. Holland, a psychiatrist.

Claimant was examined by Dr. Holland in March 1986. After obtaining a detailed history and administering a number of tests, Dr. Holland diagnosed atypical somatoform disorder. He characterized this disorder as a fixation upon the workings of the body, accompanied by subjective complaints without objective support. He indicated that the disorder represented a symptomatic aggravation of preexisting personality traits and opined that the major contributing cause of the disorder was the belief induced in claimant by his doctors that he had been severely damaged by pesticide exposure. The insurer issued a partial denial of further treatment for claimant's ongoing complaints in April 1986. The accepted portion of the claim was closed by Determination Order later the same month with no award of permanent disability.

At the hearing, claimant testified that he continued to experience difficulty breathing and that he had difficulty thinking

clearly. Dr. Leveque testified that, in his opinion, claimant had been exposed to pesticides in sufficient quantities to cause physical effects and that claimant in fact continued to experience physical effects from the exposure. Drs. Bardana and Holland also testified and, with some elaboration, reiterated their previous opinions.

The Referee concluded that claimant had failed to prove that he continued to experience any physical effects from pesticide exposure. Instead, he found that claimant's ongoing complaints were psychological in origin. Regarding the compensability of the psychological condition, the Referee concluded that the condition had been induced by Dr. Leveque's course of treatment, which had reinforced claimant's belief that he had been severely injured by exposure to pesticides. The Referee then concluded that Dr. Leveque's course of treatment was not reasonable and necessary, ostensibly because it was based upon a misdiagnosis of claimant's condition and was ineffective, and ruled claimant's psychological condition not compensable for that reason.

On Board review, claimant's major argument is that his psychological condition is compensable regardless of whether the medical treatment which caused it was reasonable and necessary. We agree. Claimant was exposed to toxic concentrations of pesticides and experienced symptoms as a result. These symptoms required medical treatment and thus represented a compensable occupational disease. See Collins v. Hygenic Corp., 86 Or App 484 (1987). The symptoms were, in fact, accepted by the insurer as a compensable occupational disease. Claimant, in good faith, sought treatment for this disease. The fact that Dr. Leveque may have misdiagnosed claimant's condition and rendered treatment that was unnecessary and even harmful as a result of this misdiagnosis does not render the harmful consequences of the treatment noncompensable. 1 Larson, The Law of Workmen's Compensation §13.21, at 3-415 (1985); cf. William v. Gates, McDonald & Co., 300 Or 278, 281-82 (1985). Therefore, we set aside the insurer's partial denial to the extent that it denied the compensability of the psychological condition diagnosed by Dr. Holland as "atypical somatoform disorder."

Regarding the attorney fee issue, claimant's attorney has indicated that upon request he would provide a statement setting forth his services in this case. Claimant's attorney should submit such a statement with a motion for reconsideration if he is not satisfied with the attorney fee awarded below.

ORDER

The Referee's order dated February 26, 1987 is reversed in part. That portion of the order that upheld that portion of the insurer's partial denial dated April 8, 1986 which denied claimant's psychological condition (atypical somatoform disorder) is reversed. The remainder of the insurer's partial denial is upheld. Claimant's attorney is awarded $1,000 for services at the hearing and $400 for services on Board review, to be paid by the insurer.

BARBARA D. OLINGHOUSE, Claimant
Malagon & Moore, Claimant's Attorneys
Roberts, et al., Defense Attorneys

WCB 86-01750
January 12, 1988
Order on Review

Reviewed by Board Members Ferris and Crider.

Claimant requests review of Referee Myers' order that upheld the insurer's partial denial relating to a psychological condition. If the Board overturns the insurer's denial, claimant requests that her attorney be granted an extraordinary attorney fee. The issues are compensability and attorney fees.

Claimant began working for the employer, a wholesale nursery, in March 1984. Her duties included plant propagation, fertilization, sales and general plant care. During the spring of 1985, insect pests began to multiply and a number of plants also became infected with a disease called Pseudomonas. Claimant's coworkers began spraying the plants with a variety of organophosphate and carbamate chemicals in an attempt to eradicate the pests and control the disease. In addition, on at least one occasion, the employer applied organophosphates through the nursery's fertilization system. Claimant often had to work in the employer's greenhouses soon after the plants were sprayed with insecticides and sometimes had to handle plants which were wet with spray.

Claimant began to notice skin rashes soon after beginning her employment. Early in the summer of 1985, she also began to experience symptoms which included shortness of breath, headaches, lethargy, forgetfulness, mood swings, nausea, abdominal cramps, diarrhea, muscle weakness and excessive perspiration. By the end of July, several of claimant's coworkers were complaining of similar symptoms and health officials inspected the employer's premises. The employer was cited for a number of violations which exposed workers to increased risk of pesticide contamination.

Claimant filed a workers' compensation claim and sought treatment from Dr. Church, a family practitioner, and Dr. Redfield, a specialist in occupational medicine. Claimant left work and her symptoms began to improve. Blood and urine tests taken about that time failed to reveal any chemical residue in claimant's body. Dr. Redfield diagnosed apparent exposure to organophosphate and other pesticides, with residual symptoms.

In mid-August, claimant and a number of coworkers were referred to Dr. Leveque, an osteopath with expertise in toxicology. After that, claimant and her coworkers met with Dr. Leveque about once per week for a number of months. During these meetings, claimant and her coworkers discussed their symptoms. Dr. Leveque prescribed some medications, but otherwise rendered no active treatment.

Based upon claimant's subjective complaints, Dr. Leveque concluded that claimant had been severely poisoned by pesticides and referred her to Dr. Kurlychek, a neuropsychologist. Dr. Kurlychek administered a number of tests and interpreted them to show impairment of fine motor coordination and disruption of attention and concentration abilities. He concluded that these problems were related to claimant's exposure to pesticides at work and anticipated that the problems would continue for up to a year as the chemical residues slowly dissipated from claimant's body.

In November 1985, claimant was examined by Dr. Bardana, the Head of the Allergy and Clinical Immunology Division of the Oregon Health Sciences University. At the time of the examination, claimant complained of continued problems with headaches, lethargy, forgetfulness, mood swings, abdominal cramps and diarrhea. From the history recited by claimant regarding her work activities and subsequent symptoms, Dr. Bardana diagnosed possible acute, transient carbamate/organophosphate intoxication and contact dermatitis. He did not think, however, that claimant's ongoing symptoms were due to chemical exposure because, according to Dr. Bardana, the pesticides to which claimant was exposed decompose into harmless chemicals within a few days. Instead, he attributed claimant's ongoing symptoms to preexisting psychological factors. Similar conclusions were later expressed by Dr. Bayer, the Director of the Poison Center of the Oregon Health Sciences University.

In Janaury 1986, the insurer notified claimant that it was accepting her claim for "acute, transient carbamate/organophosphate intoxication" and "contact dermatitis." It deferred acceptance or denial of any psychological condition pending an examination by Dr. Holland, a psychiatrist.

Claimant was examined by Dr. Holland in April 1986. After obtaining a detailed history and administering a number of tests, Dr. Holland diagnosed claimant's condition as "psychological factors affecting physical condition." He indicated that the condition represented a symptomatic aggravation of preexisting personality traits and indicated that the major cause of the disorder was the belief induced in claimant by her doctors that she had been severely damaged by pesticide exposure. The insurer issued a partial denial of further treatment for claimant's ongoing complaints in May 1986. The accepted portion of the claim was closed by Determination Order later the same month with no award of permanent disability. The insurer issued a second partial denial in June 1986 to the same effect as the first.

Claimant was examined by another psychiatrist, Dr. Radmore, in June and July 1986. Dr. Radmore agreed with Dr. Holland that many of claimant's symptoms were more characteristic of a psychological reaction than to pesticide exposure. She thought, however, that Dr. Holland had overemphasized claimant's preexisting psychological makeup in arriving at his diagnosis. She diagnosed an adjustment disorder with anxious mood and panic disorder secondary to acute, transient organophosphate intoxication and complicated by iatrogenic factors.

At the hearing, claimant testified that she continued to experience difficulty with her memory, concentration and with fine motor skills. Dr. Leveque testified that, in his opinion, claimant had been exposed to pesticides in sufficient quantities to cause physical effects and that claimant in fact continued to experience physical effects from the exposure. Drs. Bardana and Holland also testified and, with some elaboration, reiterated their previous opinions.

The Referee concluded that claimant had failed to prove that she continued to experience any physical effects from pesticide exposure. Instead, he found that claimant's ongoing complaints were psychological in origin. Regarding the compensability of the psychological condition, the Referee concluded that the condition had been induced by Dr. Leveque's course of treatment, which had

reinforced claimant's belief that she had been severely injured by exposure to pesticides. The Referee then concluded that Dr. Leveque's course of treatment was not reasonable and necessary, ostensibly because it was based upon a misdiagnosis of claimant's condition and was ineffective, and ruled claimant's psychological condition not compensable for that reason.

On Board review, claimant's major argument is that her psychological condition is compensable regardless of whether the medical treatment which caused it was reasonable and necessary. We agree. Claimant was exposed to toxic concentrations of pesticides and experienced symptoms as a result. These symptoms required medical treatment and thus represented a compensable occupational disease. See Collins v. Hygenic Corp., 86 Or App 484 (1987). The symptoms were, in fact, accepted by the insurer as a compensable occupational disease. Claimant, in good faith, sought treatment for this disease. The fact that Dr. Leveque may have misdiagnosed claimant's condition and rendered treatment that was unnecessary and even harmful as a result of this misdiagnosis does not render the harmful consequences of the treatment noncompensable. 1 Larson, The Law of Workmen's Compensation §13.21, at 3-415 (1985); cf. Williams v. Gates, McDonald & Co., 300 Or 278, 281-82 (1985). Therefore, we set aside the insurer's partial denials to the extent that they denied the compensability of the psychological conditions diagnosed by Dr. Radmore as "adjustment disorder with anxious mood" and "panic disorder."

Regarding the attorney fee issue, claimant's attorney has indicated that upon request he would provide a statement setting forth his services in this case. Claimant's attorney should submit such a statement with a motion for reconsideration if he is not satisfied with the attorney fee awarded below.

ORDER

The Referee's order dated February 26, 1987 is reversed in part. That portion of the order that upheld that portion of the insurer's partial denials dated May 15 and June 13, 1986 which denied claimant's psychological conditions (adjustment disorder with anxious mood and panic disorder) are reversed. The remainders of the insurer's partial denials are upheld. Claimant's attorney is awarded $1,000 for services at the hearing and $400 for services on Board review, to be paid by the insurer.

LEON E. COWART, Claimant
Galton, et al., Claimant's Attorneys
Ruth Cinniger (SAIF), Defense Attorney

WCB 84-02070
January 15, 1988
Order on Remand

This matter is before the Board on remand from the Court of Appeals. Cowart v. SAIF, 86 Or App 748 (1987). We have been mandated to determine whether claimant had good cause under ORS 656.319(1)(b) for failing to timely request a hearing on a denied claim in light of the standard set forth in ORCP 71(B)(1) and the cases decided under former ORS 18.160. Our task on remand, therefore, is to determine whether claimant failed to timely request a hearing on account of "mistake, inadvertence, surprise or excusable neglect" of a type that would permit relief from a judgment in a civil action. See Anderson v. Publishers Paper Co., 78 Or App 513, rev den 301 Or 666 (1986).

The relevant facts are set forth in the court's opinion, 86 Or App at 750, and will not be fully repeated here. Suffice it to say that SAIF sent a copy of its denial to claimant but not to his attorney and a request for hearing was not timely filed because claimant assumed that his attorney had been sent a copy of the denial and would request a hearing on his behalf. We have found no cases under ORCP 71(B)(1) or former ORS 18.160 which are directly on point. The case of Harp v. Loux, 54 Or App 840 (1981), rev den 292 Or 589 (1982), however, is instructive.

In that case, a default judgment was granted in favor of the plaintiff against a non-appearing defendant. The insurer of the defendant moved to set aside the judgment under former ORS 18.160 on the ground that it had not been notified of the action by the plaintiff even though the plaintiff knew that it was the defendant's insurer. The court rejected this argument, stating that the insurer's interest in the case was derivative in nature and that there was no legal requirement that the plaintiff notify the insurer of the action. 54 Or App at 847-49.

In the present case, SAIF sent a copy of its denial to claimant in accordance with ORS 656.262(6) and applicable regulations. Claimant's attorney was not a party to the action and there was no legal requirement that SAIF notify the attorney of the denial of claimant's claim. It was claimant's duty to ensure that a request for hearing was timely filed, either personally or through his attorney. Claimant failed to fulfill that duty. We conclude, in light of Harp v. Loux, supra, that this failure did not occur through mistake, inadvertence, surprise or excusable neglect within the meaning of ORCP 71(B)(1) or former ORS 18.160. We, therefore, conclude that claimant has failed to show good cause for failing to timely file his request for hearing and that the Referee did not have jurisdiction to consider the request. We thus adhere to and republish our prior order dated August 12, 1986, as supplemented herein, effective this date.

IT IS SO ORDERED.

Board Member Crider, dissenting:

I dissent. I conclude that claimant had good cause for failure to request hearing within 60 days of SAIF's December 13, 1983 denial. The issues raised by his February 23, 1984 request for hearing should be addressed on the merits.

Claimant filed a workers' compensation claim related to his back in June, 1981. The record first indicates that claimant had retained attorney, Willard E. Merkel, in September, 1982 when temporary disability benefits were suspended for failure to participate in a rehabilitation program. At that time, claimant's attorney sought claimant's records, and thereafter was actively involved in the case. Claimant and his attorney agreed, when the attorney was retained, that the attorney would take care of all matters and that claimant should not deal directly with the insurer.

In November, 1982, Mr. Merkel filed a document entitled "Motion for Order to Show Cause" the body of which requested a hearing on the temporary disability issue. SAIF received the Motion on November 10. A show cause order issued; the parties appeared on December 9 through counsel; some issues were

apparently resolved and the hearing on the penalty and attorney fee issues was postponed. Throughout the following year, SAIF's claims examiners and attorneys were in repeated contact with Mr. Merkel. The hearing was apparently never reset; but the issues were resolved by stipulation approved February 3, 1984.

In the meantime, on December 13, 1983, SAIF issued a partial denial related to a low back condition. The denial was directed to claimant but not to his attorney. Claimant received a copy of the denial letter on January 9, some time after he had executed the stipulation resolving earlier disputes. He did not notify his attorney of the denial because he understood that the attorney would receive copies of everything and deal with them. When the attorney learned of the denial, a request for hearing was filed. It was filed 11 days after the 60 days for filing a request had run, well within the 180 days within which a request can be filed with "good cause." ORS 656.319(1)(b).

The Court of Appeals has directed us to determine, in light of the law under ORCP 71(B)(1) and former ORS 18.160, whether there was good cause for the late filing. I find that there was good cause. The majority's reliance on Harp v. Loux, 54 OR App 840 (1981), rev den 292 Or 589 (1982) is misplaced. In that case a default judgment was taken in a case arising out of a motor vehicle accident. The defendant's insurer, who was not a party to the action and was not required to be served, then entreated the court to set aside its default judgment. The court refused as nothing in the law required that plaintiff notify an insurer of a lawsuit. Rather, it was the insured's contractual duty to notify the insurer that had been breached. In the absence of a legal duty to notify the insurer, the court refused to find failure to notify to be good cause for setting aside the default judgment.

In this case, however, the insurer, who seeks to take advantage of claimant's failure to request hearing within 60 days, was under an obligation--albeit not a statutory one--to notify claimant's counsel of the denial. At the time of the denial, the November, 1982 request for hearing was pending; therefore, under OAR 438-07-015, the insurer was required to send counsel all new information pertaining to the claim as it was generated. It failed to fulfill that duty; therefore, the Harp analysis does not dispose of the matter. Indeed, it would tend to support the contention that claimant had good cause for failure to act independently.

The case of May v. May, 55 OR App 396 (1981) sheds more light on this problem. In that case the court did set aside a default judgment against a woman who failed to respond to a petition for dissolution and custody order because she believed her attorney had "filed 'some paper'" which ensured that she could contest the petition. He had not. However, the court reasoned that the woman's misunderstanding was reasonable and excusable. I would find that claimant's reliance on his understanding was reasonable in light of the fact that the insurer was under a duty to provide documents related to the claim to his attorney and in the past had satisfied that duty and that he had been instructed by counsel to allow counsel to take care of the conduct of the case. Therefore, his failure to request a hearing or call the denial to his attorney's attention was excusable. The Referee properly concluded that the request for hearing was timely.

THERESA L. HESS, Claimant
Joel Lieberman, Claimant's Attorney
Roberts, et al., Defense Attorneys

WCB 86-13594
January 15, 1988
Order on Review

Reviewed by Board Members Johnson and Ferris.

The insurer requests review of those portions of Referee Tuhy's order that: (1) set aside as premature a Determination Order closing claimant's claim for a low back injury; and (2) awarded claimant's attorney an attorney fee for the insurer's unreasonable delay in the acceptance of her claim even though the Referee found there was no compensation due as a result of this delay. If the Board reverses the Referee on the premature closure issue, the insurer contends that the Determination Order, which granted no award of permanent partial disability, should be affirmed. In her respondent's brief, claimant contends that the insurer misapplied a portion of the Referee's order which authorized an offset of overpaid temporary total disability compensation against temporary disability compensation payable pursuant to the Referee's ruling on the premature closure issue. With her brief, she submits a letter from the insurer which accompanied and explained the insurer's payment of compensation pursuant to the Referee's order. The issues are premature closure, extent of disability, attorney fees and offset.

The Board affirms the order of the Referee with the following comment on the offset issue. The offset issue concerns the insurer's compliance with the Referee's order and is based upon events which occurred after the Referee closed the record. The Board's review is limited to the record developed by the Referee. See ORS 656.295 (3) & (5). The Board, therefore, may not consider the post-hearing evidence submitted by claimant and may not decide the question of compliance with the Referee's order on direct review of that order.

ORDER

The Referee's order dated February 3, 1987, as amended by the order dated February 13, 1987, is affirmed. Claimant's attorney is awarded $500 for services on Board review, to be paid by the insurer.

BARBARA J. BROWN, Claimant
Pozzi, et al., Claimant's Attorneys
G. Howard Cliff, Defense Attorney

WCB 85-15686
January 20, 1988
Order Dismissing Request for Review and Remanding

The insurer has requested Board review of Referee St. Martin's November 25, 1987 letter in the event that it is construed to be an order. We have reviewed the request to determine whether the Referee's letter is a final order which is subject to review. Zeno T. Idzerda, 38 Van Natta 428 (1986).

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

Here, the Referee's letter did not contain a statement explaining the parties' rights of appeal pursuant to ORS 656.289(3). Moreover, it neither finally disposed of, nor

allowed, claimant's claim for permanent total disability. Finally, the letter did not formally fix the amount of claimant's compensation. Instead, the letter offered the Referee's preliminary impressions concerning the issues raised at the hearing.

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

Accordingly, the request for Board review is dismissed.

IT IS SO ORDERED.

PEDRO G. ALCALA, Claimant
Michael B. Dye, Claimant's Attorney
Garrett, et al., Defense Attorneys

WCB 86-05800
January 21, 1988
Order Denying Motion for Reconsideration

The insurer has requested reconsideration of the Board's December 11, 1987 Order on Review that affirmed the Referee's order which had upheld the insurer's denial of responsibility for claimant's aggravation claim. Specifically, the insurer objects to the Board's finding that it had conceded the issue of compensability and sought to defend against claimant's aggravation claim solely on the basis of responsibility.

The insurer's request for reconsideration was mailed on the same day that claimant petitioned for judicial review of the Board's order. We have previously held that it is possible to withdraw an order for reconsideration after the filing of a petition for judicial review with the Court of Appeals. Dan W. Hedrick, 38 Van Natta 208, 209 (1986). However, we exercise this authority rarely. Ronald D. Chaffee, 39 Van Natta 1135 (November 12, 1987).

Under these circumstances, we decline to grant the request. The issuance of this order neither "stays" our prior order nor extends the time for seeking review. International Paper Company v. Wright, 80 Or App 444 (1986); Fischer v. SAIF, 76 Or App 656 (1985).

IT IS SO ORDERED.

DEANE G. BRISTOW, Claimant
Malco & Glode, Claimant's Attorneys
Beers, Zimmerman & Rice, Defense Attorneys

WCB 86-12484
January 21, 1988
Order on Review

Reviewed by Board Members Ferris and Johnson.

The insurer requests review of that portion of Referee Howell's order which found that claimant's low back injury claim had been prematurely closed. Should we find that the claim was properly closed, the insurer argues that the 5 percent (16 degrees) unscheduled permanent disability, awarded by Determination Order, be upheld, while claimant argues that it should be increased. On review, the insurer contends that the claim was not prematurely closed. We agree and reverse.

Claimant, a 38-year-old mechanic, compensably injured his neck, right shoulder and back on September 22, 1981, while cleaning metal on a truck. He treated conservatively with Dr. Ray, a chiropractor, who released him for modified work.

On March 21, 1983, claimant compensably reinjured his low back while installing a tractor starter. Dr. Ray diagnosed, inter alia, an L4-5 and S1 disc herniation claimant was taken off work. In April 1983 he was released for modified work.

Dr. Ray continued to treat claimant during the next two years. In June 1985, claimant's condition began to worsen. He was referred to Dr. Tsai, a neurologist, who diagnosed left L5 radicular compression due to traumatic herniated nucleus pulposis at L4-5. Claimant was taken off work in late July 1985. Following more frequent treatments from Dr. Ray, his condition subsequently improved and he returned to modified work in mid-August 1985. Dr. Ray reported dramatic improvement in claimant's symptoms in October 1985.

On October 10, 1985, claimant was examined by a panel at Independent Chiropractic Consultants (ICC). They declared him medically stationary and able to resume regular work without limitations. They added that further chiropractic care would merely be palliative.

On March 7, 1986, Dr. Ray reported his disagreement with many of ICC's findings and conclusions, opining that claimant suffered "measurable" permanent impairment in his lower spine and that he should continue modified work duties. In June 1986, Dr. Ray continued to provide what he described as palliative care on an as needed basis.

On June 17, 1986, claimant was examined by Dr. Gatterman, a chiropractor. In her July 1986 report, Dr. Gatterman declared that claimant was medically stationary with minimal impairment.

On August 4, 1986, Dr. Ray reported continuing palliative treatment and opined that claimant was not medically stationary because "maximum material improvement has not been reached through treatment or with time." Although Dr. Ray continued to release claimant for modified work, he felt that claimant's condition would deteriorate, eventually rendering him unable to work in his occupation.

The claim was closed by Determination Order on August 25, 1986, which awarded claimant 5 percent unscheduled permanent disability and temporary disability through the designated medically stationary date of March 6, 1986. Claimant was paid temporary partial disability compensation through August 11, 1986.

On August 27, 1986, Dr. Ray expressed agreement with most of Dr. Gatterman's July 1986 report. He disagreed with some of her objective findings, noting that Dr. Gatterman saw claimant during a period of remission when he was inactive subsequent to unrelated knee surgery. Dr. Ray reported that claimant continued to receive palliative treatment on a need basis.

The Referee set aside the Determination Order as premature. In reaching this conclusion, the Referee was persuaded by the opinion of Dr. Ray. We disagree.

"Medically stationary" means that "no further material improvement would reasonably be expected from medical treatment, or

the passage of time." ORS 656.005(17). In determining whether a claim was prematurely closed, we determine whether claimant's condition was medically stationary on the date of closure. Scheuning v. J. R. Simplot & Company, 84 Or App 622, 625, rev den 303 Or 590 (1987).

Dr. Ray, claimant's treating chiropractor, opined in August 1986, prior to claim closure, that claimant was not medically stationary. Thereafter, he offered no further opinion on claimant's medically stationary status. We generally give greater weight to the treating physician's opinion, absent persuasive reasons not to do so. Weiland v. SAIF, 64 Or App 810, 814 (1983). We find persuasive reasons not to do so here.

Although Dr. Ray accurately described the concept of "medically stationary" and stated that maximum physical improvement had not yet been achieved with treatment or time, there is no indication that he expected claimant's condition to improve with either treatment or time. On the contrary, he expected eventual deterioration in claimant's condition.

In addition, Dr. Ray's reports in June and August 1986 describe his continued treatments as "palliative" in nature. Finally, although not specifically finding claimant medically stationary, Dr. Ray proceeded to rate his permanent impairment in March 1986. Such an assessment implicitly presumes a stationary condition.

These apparent inconsistencies and Dr. Ray's failure to explain why he believed claimant was not medically stationary lead us to discount his opinion. Rather, we are more persuaded by the findings and conclusions of ICC and Dr. Gatterman that claimant's condition was medically stationary. The claim was therefore properly closed.

We find, however, that claimant was not medically stationary on March 6, 1986, the date designated by the Determination Order. Dr. Gatterman found claimant stationary as of June 17, 1986. Dr. Ray reviewed Gatterman's report and, in his final report on August 27, 1986, did not dispute this finding. Accordingly, we modify the reinstated Determination Order to show that claimant was medically stationary on June 17, 1986.

On the extent of disability issue, we find the record sufficiently developed for our review. See ORS 656. 295(5); David L. Fleming, 38 Van Natta 1321 (1986), aff'd mem Fleming v. Daeuble Logging, __ Or App __ (December 16, 1987). Following our de novo review of the record, with due regard for claimant's physical limitations and relevant social and vocational factors, we conclude that a 5 percent unscheduled permanent disability award provides adequate compensation for the loss of earning capacity resulting from his low back condition. See ORS 656.214(5). Accordingly, we affirm that portion of the Determination Order.

ORDER

The Referee's order dated March 30, 1987 is reversed. The August 25, 1986 Determination Order is reinstated and modified to award claimant additional temporary partial disability compensation through June 17, 1986, the medically stationary date. Claimant's attorney fee shall be adjusted accordingly.

TONI A. DRAGT, Claimant
Coons & Cole, Claimant's Attorneys
Miller, Nash, et al., Defense Attorneys
SAIF Corp Legal, Defense Attorney

WCB 86-06588 & 86-05442
January 21, 1988
Order on Review

Reviewed by Board Members Johnson and Ferris.

Claimant requests review of Referee Howell's order that declined to assess a penalty and attorney fee for the SAIF Corporation's failure to continue paying temporary disability benefits after its denial of responsibility for claimant's aggravation claim. Claimant also requests clarification of the effect of her settlement with SAIF, which was also incorporated into the Referee's order. On review, the issues are jurisdiction and penalties and attorney fees.

We affirm with the following comment regarding the jurisdictional issue.

The sole issue at hearing was whether SAIF unreasonably failed to pay temporary disability benefits. By order dated February 6, 1987, the Referee declined to assess a penalty and attorney fee.

The parties subsequently entered into a settlement, in which SAIF agreed to accept responsibility for claimant's condition. On February 18, 1987, the Referee issued an amended order to incorporate that settlement. The amended order dismissed claimant's hearing request as to SAIF, expressly reserving the issue of the appropriate rate of temporary disability.

The amended order did not expressly reserve the penalty and attorney fee issue argued at hearing and addressed in the Referee's prior order. It did, however, republish the prior order addressing this issue.

On review, claimant notes that the amended order could be interpreted as dismissing the penalty and attorney fee issue. Claimant contends that this was not the intent of the parties. She requests that the Board either interpret the amended order as not dismissing that issue, or remand the case for additional evidence on the intent of the parties. SAIF has not addressed this issue.

We agree that the language of the amended order is somewhat confusing. However, we note that the amended order also republished the Referee's prior order which addressed the penalty and attorney fee issue. As a result, we interpret the amended order as also reserving the penalty and attorney fee issue.

ORDER

The Referee's order dated February 18, 1987 is affirmed.

DOUGLAS L. FARLEY, Claimant
Ackerman, et al., Claimant's Attorneys
Brian L. Pocock, Defense Attorney

WCB 86-09282
January 21, 1988
Order on Review

Reviewed by Board Members Ferris and Johnson.

The self-insured employer requests review of that portion of Referee Seymour's order that increased claimant's unscheduled permanent disability for a neck and back condition from 15 percent (48 degrees), as awarded by a Determination Order, to 40 percent (128 degrees). Claimant cross-requests review, apparently seeking a greater permanent disability award. The issue is extent of unscheduled permanent disability.

We modify the Referee's order.

Claimant, 45 at hearing, compensably injured his neck and back in May 1985, while working as a truck driver. Shortly thereafter, he was examined by Dr. Walborn, treating chiropractor. Walborn diagnosed a compression injury to the cervical spine.

In June 1985, claimant returned to work as a truck driver. However, due to increased back pain he was taken off work on July 1, 1985. Thereafter, he continued to treat with Dr. Walborn.

In May 1986, claimant was evaluated by the Independent Chiropractic Consultants. The Consultants found few objective findings and minimal physical impairment. In June 1986, Dr. Walborn restricted claimant to medium work and no frequent lifting in excess of 50 pounds. That same month, Dr. O'Fallon, M.D., restricted claimant to sedentary work and no frequent lifting in excess of 10 pounds. Shortly thereafter, a Determination Order issued awarding claimant 15 percent unscheduled permanent disability.

In July 1986, claimant returned to work as an insurance salesman. The next month, he was examined by Dr. Schacner, surgeon. Schacner found no objective findings and felt it was unnecessary to limit claimant's physical activities. After working approximately four months as an insurance salesman, claimant quit for reasons unrelated to his compensable injury.

In addition to working as an insurance salesman and truck driver, claimant has worked as a veneer dryer, service station manager, night watchman, and general laborer. He is educated through the 11th grade and has a GED certificate.

Claimant testified that he is physically unable to return to any of his former jobs, other than that of an insurance salesman. He cannot drive long distances and takes Tylenol for pain.

Finding that claimant was foreclosed from a large portion of the labor market, the Referee increased claimant's unscheduled permanent disability award to 40 percent. We agree that claimant is entitled to a permanent disability award in excess of the 15 percent awarded by the Determination Order. However, we consider the Referee's award to be excessive.

In rating the extent of unscheduled permanent disability for claimant's neck and back 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, 296 Or 505, 510 (1984).

Here, Dr. Walborn released claimant to medium work with a 50 pound lifting restriction. The Independent Chiropractic Consultants found that claimant was minimally physically impaired. Dr. Schacner found no objective findings of impairment and placed no restrictions on claimant's physical activities. Lastly, claimant successfully returned to work as an insurance salesman, but quit for reasons unrelated to his disability.

After our our de novo review of the medical and lay evidence, including claimant's testimony, and considering the relevant social and vocational factors, we conclude that a total award of 25 percent unscheduled permanent disability adequately compensates claimant for his loss of earning capacity due to the compensable injury.

ORDER

The Referee's order dated February 24, 1987, is modified. In addition to claimant's award by Determination Order of 15 percent (48 degrees) unscheduled permanent disability, he is awarded 10 percent (32 degrees) unscheduled permanent disability, for a total award to date of 25 percent (80 degrees). The award of attorney fees shall be adjusted accordingly.

LEONARD HENDERSON, Claimant
Coons & Cole, Claimant's Attorneys
Roberts, et al., Defense Attorneys

WCB TP-87007
January 21, 1988
Third Party Distribution Order

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

In October 1982, claimant suffered a compensable injury when the van in which he was riding was struck from behind by another vehicle. His condition was diagnosed as cervical and thoracic strain. Treatment has been conservative, primarily consisting of neck traction, bracing, heat, ultrasound, massage, exercises, and medication. With some restrictions, he has been able to continue working as a cameraman for a television station.

Claimant last sought medical treatment in April 1986. At that time, the paying agency had incurred $1,310.50 in expenses for treatment, physical therapy, and a neck brace. Following the April 1986 examination, Dr. Baker, claimant's treating orthopedist, opined that he "most probably would benefit greatly" from an anterior cervical fusion. Dr. Baker's opinion is based upon a diagnosis of cervical spondylosis and instability, which is "most probably directly related" to the compensable injury. Dr. Baker does not attribute the surgery option to either a preexisting condition or claimant's previous gymnastic activities, as he had initially suggested. Claimant remains undecided concerning the necessity of this surgical procedure.

Dr. Fry, orthopedist, has conducted an independent medical examination. Diagnosing a cervical strain superimposed on

"probably preexisting spondylosis," Dr. Fry has found no positive indication for performing a fusion. However, Dr. Fry concedes that such an indication could exist in the future.

Dr. Rockey, orthopedist, has also performed an independent medical examination. Stating that Dr. Baker's treatment recommendations were appropriate, Dr. Rockey agrees that claimant's lack of prior problems suggests a compensable relationship. Yet, Dr. Rockey has also concluded that claimant's symptoms are, at least, partially preexisting.

In December 1986, with the paying agency's approval, claimant settled his third party civil action for $30,000. After deducting claimant's attorney fees, litigation costs, and the 1/3 statutory share, the remaining balance of the recovery equals $13,158.07. To date, claim costs, consisting of a 10 percent unscheduled permanent disability award and medical expenses, have totalled $4,640.30. These costs have been fully reimbursed to the paying agency.

The paying agency asserts entitlement to the remaining balance of the recovery as a reserve for anticipated future expenses. Specifically, it contends that claimant will require cervical surgery. Even excluding the costs of surgery, which it estimates to be $10,000, the paying agency projects future medical expenditures of $1,000.

Claimant does not dispute the cost estimate for the surgery. However, he contends that the paying agency has failed to establish to a reasonable certainty that it will incur such future claim costs. Furthermore, considering that he has seldom sought medical treatment since the compensable injury and has not submitted a medical services claim since April 1986, claimant disagrees with the $1,000 projection. Instead, he submits that the record does not support the agency's entitlement to a lien for future medical services in any amount.

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

Any conflict as to the amount of the balance which may be retained by the paying agency shall be resolved by the Board. ORS 656.593(1)(d). To support its lien for anticipated future expenditures, the paying agency must establish that it is reasonably certain to incur such expenditures. Robert T. Gerlach, 36 Van Natta 293, 297 (1984); Gerald Herrington, 35 Van Natta 859, 860 (1983); Leroy R. Schlecht, 32 Van Natta 261 (1981), rev'd in part on other grounds Schlecht v. SAIF, 60 Or App 449 (1982).

If, and when, claimant requests authorization for surgery, the paying agency has expressed its intention to contest its responsibility for the underlying cervical spondylosis condition. Consequently, it submits that it is in an untenable

situation if it is prohibited from retaining an adequate reserve and claimant subsequently elects to undergo the surgery, without a worsening of his condition. That is, assuming that the surgery is ultimately found compensable, the paying agency asserts that it would be left without any potential recovery, despite the surgery recommendation prior to the distribution of the third party settlement proceeds.

We addressed a similar issue in Robert T. Gerlach, supra. In Gerlach, the paying agency claimed that it should be entitled to retain funds from the proceeds of a third party recovery equal to the estimated cost of a corneal transplant operation. The agency argued that it was unfair to allow the claimant to "elect" not to pursue his only possible medical option at the time of a third party distribution, and then several years later, when his condition remained the same, allow him to exercise his option to undergo surgery and thereby require the paying agency to assume financial responsibility with no recourse against the funds obtained by the claimant from the ultimate wrongdoer, i.e., the third party tortfeasor. We stated that, to a certain extent, we shared this sentiment. However, we reasoned that the problem is inherent in ORS 656.593(1)(c), which provides the paying agency with the right to be paid and retain a portion of the claimant's third party recovery for the present value of its reasonably to be expected future expenditures for compensation. Gerlach, supra, page 297.

In Gerlach, all physicians indicated that the procedure was entirely elective. Moreover, the chances of obtaining a successful corneal transplant were relatively low. We were persuaded that if the claimant eventually decided to have the surgery the paying agency would be obligated to pay this expense pursuant to ORS 656.245. Yet, considering the claimant's apparent intentions and the contingencies and uncertainties involved in the transplant procedure, we were unable to conclude that it was reasonably certain that the surgery would be performed. Accordingly, we held that the paying agency was not entitled to a lien for its anticipated future expenditures for the corneal transplant.

In reaching our decision in Gerlach, we distinguished Gerald Herrington, 35 Van Natta 859, 861 (1983). In Herrington, the claimant's treating physician had repeatedly stated that cataract surgery would eventually be required. In addition, unlike the situation in Gerlach, there was no evidence that the surgery might be unsuccessful. Consequently, in Herrington, we concluded that it was reasonably certain that the claimant eventually would require the surgery. Therefore, we directed that the paying agency recover sufficient funds to satisfy that portion of its lien attributable to this anticipated future medical expenditure.

Here, a cervical fusion has been offered as an option that "most probably would benefit [claimant] greatly." Yet, considering the remaining medical opinions and claimant's consistent reluctance to undergo the procedure, the likelihood of future surgery can best be described as a possibility. In any event, we are unable to conclude that it is reasonably certain that the surgery will be performed. Moreover, the medical evidence suggests that the surgery's causal relationship to the compensable injury is in question. In fact, the paying agency acknowledges that it will dispute the compensability of the

surgery and claimant's underlying spondylosis if, and when, a request for authorization is submitted. Under these circumstances, we conclude that the paying agency is not entitled to a lien for its anticipated future expenditures for cervical surgery.

Finally, the parties concede that, between January 1983 and April 1986, the paying agency incurred medical expenses totalling $1,310.50. However, the record fails to establish that it is reasonably certain that claimant will require future medical services as a result of his compensable injury. Furthermore, assuming that the certainty of compensable future services had been confirmed, the present value of those services has not been established.

Accordingly, we hold that the paying agency is not entitled to a lien for anticipated future expenditures. The remaining balance of the third party recovery shall be distributed to claimant in accordance with ORS 656.593(1)(d).

IT IS SO ORDERED.

DEBORAH A. HUTTON, Claimant
Merrill Schneider, Claimant's Attorney
CNA Insurance, Defense Attorney

WCB TP-87019
December 11, 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 $5,000. The paying agency's lien is presently $4,804.65.

The paying agency opposes the current settlement offer. Contending that claimant was not "at fault" in the third party accident, the agency asserts that it is entitled to full protection of its lien for claimant's incurred medical expenses, as well as her 5 percent (16 degrees) unscheduled permanent disability award.

The Board is authorized to resolve disputes concerning the approval of any compromise of a third party action. See ORS 656.587. In exercising this authority, we employ our independent judgment to determine whether the compromise is reasonable. Natasha D. Lenhart, 38 Van Natta 1496 (1986). Generally, we will approve settlements negotiated between a claimant/plaintiff and a third party defendant, unless the settlement amount appears to be grossly unreasonable. Steven B. Lubitz, 39 Van Natta 809; Virginia Merrill, 35 Van Natta 251 (1983); Rose Hestkind, 35 Van Natta 250 (1983).

Applying the aforementioned standards to the present record, we find the proposed settlement reasonable. Consequently, the settlement offer of $5,000 is approved. Furthermore, the proceeds of the settlement shall be distributed in accordance with ORS 656.593(1).

IT IS SO ORDERED.

ROBERT J. BEATY, Claimant
Malagon & Moore, Claimant's Attorneys
SAIF Corp Legal, Defense Attorney

Own Motion 84-0198M
January 27, 1988
Order Awarding Penalties/Fees

Claimant has requested that the Board award penalties and an attorney fee for SAIF Corporation's delay in paying benefits as directed by the Board's June 24, 1987 order. SAIF Corporation is in agreement with the relief claimant seeks.

Claimant is hereby granted a penalty equal to 25 percent of all amounts due from the June 24, 1987 order which were not paid timely. Claimant's attorney is also granted a fee equal to $250, payable by SAIF Corporation.

IT IS SO ORDERED.

CAROL DAVIS, Claimant
Vick & Gutzler, Claimant's Attorneys
Dennis Martin (SAIF), Defense Attorney
Garrett, et al., Defense Attorneys

WCB 85-00169 &86-10997
January 27, 1988
Order on Review

Reviewed by Board Members Crider and Ferris.

Claimant requests review of those portions of Referee Michael Johnson's order that: (1) upheld the SAIF Corporation's aggravation denial of a right shoulder condition; (2) upheld Northwest Farm Bureau's "new injury" denial for the same condition; and (3) upheld the SAIF Corporation's partial denial of an ear and dizziness condition. The issues are compensability and responsibility.

The Board reverses that portion of the Referee's order that upheld SAIF's aggravation denial of claimant's right shoulder condition. All remaining portions of the Referee's order are affirmed.

Claimant compensably injured her upper back and right shoulder in February 1984, while working as a food production worker for SAIF's insured. Shortly therafter, she was seen by Dr. Pearson, chiropractor. Pearson diagnosed a thoracic strain/sprain and treated conservatively. In August 1984, claimant was evaluated by Dr. Corrigan at a pain clinic. Corrigan diagnosed a thoracic outlet compression syndrome and opined that claimant could return to regular work.

In October 1984, claimant was examined by the Orthopaedic Consultants. The Consultants found few objective findings and rated claimant's impairment as "minimal." A few months later, Dr. Pearson reexamined claimant and reported that she had permanent impairment in the upper right extremity.

In January 1985, a Determination Order issued awarding claimant 15 percent unscheduled permanent disability.

Claimant was reexamined by Dr. Pearson in April 1985. Pearson reported continuing complaints of right shoulder pain. In late 1985 or early 1986, claimant began working as a walnut packager for Farm Bureau's insured. Shortly thereafter, she reported to Dr. Grimm, neurologist, with complaints of increased right shoulder pain. Grimm, who had previously examined claimant in June 1983, diagnosed right shoulder fascitis secondary to overuse and recommended that claimant not return to work. In February 1986, Grimm reported, inter alia:

"It is my opinion that these [at-work] arm movements, combined with [claimant's] prior history of partial paralysis of the right spinal accessory nerve with a shoulder droop and C7-8 radiculopathy, in addition to rotator cuff tenderness, have all been aggravated by the job and she must retreat from the job for arm therapy."

In July 1986, claimant was examined by the Orthopaedic Consultants. The Consultants opined, inter alia:

"[Claimant's] residual complaints in so far as her right shoulder girdle pain is concerned relates to her primary injury of record while in the employ of [SAIF's insured]. The peroneal neuropathy, now resolved, apparently had its onset during the course of her employment at [Farm Bureau's insured]. There is no apparent residual from this condition which would appear to be medically stationary at this point in time."

A few months later, claimant was examined by Dr. Stoody, orthopedist. Stoody diagnosed a chronic right shoulder strain and opined that her condition had not materially worsened since the compensable February 1984 injury. In addition, Stoody felt it was "unreasonable" to attribute claimant's current condition to her activities at Farm Bureau's insured, inasmuch as "any activity," on-the-job or off-the-job, produced right shoulder complaints.

In October 1986, Dr. Grimm stated that claimant's work activities at Farm Bureau's insured caused a "new medical condition ... that ... was superimposed upon a previous underlying injury of the right shoulder ...."

Claimant testified to continuing right shoulder pain following her compensable February 1984 injury. Her pain worsened after she began working for Farm Bureau's insured, resulting in her return to Dr. Grimm.

Claimant filed an aggravation claim against SAIF and a "new injury" claim against Farm Bureau. In May 1986, SAIF denied an aggravation on the basis of responsibility. In August 1986, Farm Bureau denied a "new injury" on the basis of compensability and responsibility.

In upholding SAIF's aggravation denial, the Referee awarded claimant 10 percent additional unscheduled permanent disability and stated:

"The record contains medical reports which could easily be interpreted as sustaining an aggravation claim, but claimant has already been awarded unscheduled PPD reflecting a significant level of disability, and a larger award is hereafter granted, and such an award contemplates occasional exacerbation and remissions of a compensable injury without said changes being considered a formal 'aggravation.'"

We disagree with the Referee and find that claimant has established a valid aggravation claim, which is the responsibility of SAIF.

In cases involving issues of compensability and responsibility, like here, the threshold issue is compensability. If the claim is compensable, then the trier of fact must address the issue of responsibility. See Runft v. SAIF, 303 Or 493, 498-99 (1987). Consequently, before addressing the issue of responsibility, we examine whether claimant has established a valid aggravation claim.

In aggravation cases, the worker must prove: (1) a worsening of his condition, which makes him more disabled (i.e., less able to work) than at the time of the last arrangement of compensation; and (2) a causal relationship between the worsened condition and the compensable injury. See Smith v. SAIF, 302 Or 396 (1987); ORS 656.273(1). Increased symptoms alone are not compensable, unless the worker suffers pain or additional disability that reduces his ability to work thereby resulting in a loss of earning capacity. Smith, 302 Or at 401. A determination of whether the worker's condition has worsened cannot turn on factors unrelated to the condition of the worker's body. Gwynn v. SAIF, 304 Or 345, 349-50 (1987).

Here, the last arrangement of compensation was the January 1985 Determination Order. A few months prior to the Determination Order, Dr. Corrigan released claimant to regular work. Similarly, the Orthopaedic Consultants found few objective findings and felt claimant was employable from an orthopedic and neurologic standpoint. After the Determination Order, claimant returned to work for Farm Bureau's insured and experienced increased right shoulder pain. Thereafter, she reported to Dr. Grimm who opined that claimant's compensable February 1984 injury had been aggravated. Grimm recommended that claimant not return to work at Farm Bureau's insured. Likewise, the Consultants' found that claimant's right shoulder pain was causally related to the February 1984 injury. Moreover, claimant testified that her right shoulder pain never completely resolved following the February 1984 injury and that it steadily worsened during her employment at Farm Bureau's insured.

Accordingly, we find that claimant suffered a worsening of her right shoulder condition that resulted in a loss of earning capacity. Further, on this record, we find no evidence to support the Referee's conclusion that claimant's increased permanent disability award "contemplates occasional exacerbation and remissions." The question of whether claimant's condition worsened cannot turn on the Referee's subsequent award of an additional 10 percent unscheduled permanent disability. Gwynn v. SAIF, supra, 304 Or at 349-50.

We turn to the issue of responsibility. In Hensel Phelps Construction v. Mirich, 81 Or App 290, 294 (1986), the court announced that unless work activities at the later employer independently contribute to the worker's disability (i.e., cause a worsening of his underlying condition) then the worker has sustained a mere recurrence of symptoms and the earlier employer remains responsible.

Here, claimant testified to continuing symptoms of right shoulder pain. The Orthopaedic Consultants related claimant's current right shoulder condition to her compensable February 1984 injury and felt that she had no residuals from her work activities at Farm Bureau's insured. Likewise, Dr. Grimm felt that claimant's current condition was superimposed upon her compensable February 1984 injury.

Accordingly, after our de novo review of the medical and lay evidence, including claimant's credible testimony, we find that claimant sustained a mere recurrence of symptoms while employed at Farm Bureau's insured. Therefore, SAIF's insured, as the earlier employer, remains responsible for claimant's right shoulder condition.

Furthermore, inasmuch as Farm Bureau denied compensability and responsibility for claimant's aggravation claim, whereas SAIF denied only responsibility, Farm Bureau shall pay the attorney fee award. Karen J. Bates, 39 Van Natta 42 (1987).

ORDER

The Referee's order dated December 24, 1986, is reversed in part and affirmed in part. That portion of the Referee's order that upheld the SAIF Corporation's aggravation denial is reversed. Northwest Farm Bureau shall pay claimant's attorney a reasonable insurer-paid attorney fee of $1,200 for services at hearing and $500 for services on Board review. All remaining portions of the Referee's order are affirmed.

FRANCISCA A. DURAN, Claimant
Michael B. Dye, Claimant's Attorney
SAIF Corp Legal, Defense Attorney

WCB 85-03909 & 85-06267
January 27, 1988
Order on Remand

This matter is before the Board on remand from the Court of Appeals. Duran v. SAIF, 87 Or App 509 (1987). The court has mandated that claimant's occupational disease claim for a stress-related mental disorder be allowed.

Accordingly, SAIF's May 15, 1985 denial is set aside and the claim is remanded to SAIF for processing according to law.

IT IS SO ORDERED.

BRUCE A. HATLELI, Claimant
Bischoff, et al., Claimant's Attorneys
Malagon & Moore, Attorneys
Dennis Ulsted (SAIF), Defense Attorney
David Horne, Defense Attorney

WCB 85-02089, 85-04106, 85-07657 & 85-0758
January 28, 1988
Second Order on Remand

Claimant has requested reconsideration of the Board's December 31, 1987 Order on Remand. Pursuant to our order, claimant's attorney was awarded a reasonable attorney fee for services in connection with Wausau Insurance's untimely denial of responsibility for claimant's "new injury" claim. After review of the record and consideration of the factors discussed in Barbara A. Wheeler, 37 Van Natta 122, 123 (1985), we found that a reasonable attorney fee was $250.

In determining claimant's attorney fee award, his counsel's services before all prior forums was thoroughly considered. In addition, we note that such an award exceeds attorney fees awarded in prior cases involving similar issues. See Delbert R. Hutchinson, 39 Van Natta 32 (1987); Fred C. Spivey, 38 Van Natta 1033 (1986).

Accordingly, claimant's request for reconsideration is granted and our prior Order on Remand withdrawn. Following our further review of the record and after consideration of the aforementioned matters, we continue to find that a reasonable attorney

fee for claimant's attorney's services in connection with Wausau's late denial is $250. Consequently, on reconsideration, as supplemented herein, we adhere to and republish our former order, effective this date.

IT IS SO ORDERED.

LEONARD V. JENKINS, Claimant
Flaxel, et al., Claimant's Attorneys
Roberts, et al., Defense Attorneys

WCB 85-07550
January 28, 1988
Order on Remand

This matter is before the Board on remand from the Court of Appeals. Jenkins v. Tandy Corporation, 86 Or App 133 (1987). The court has mandated that claimant's injury claim be accepted.

Accordingly, the insurer's "de facto" denial is set aside and the claim is remanded to the insurer for processing according to law.

IT IS SO ORDERED.

SHARON L. CAVE (JACKSON), Claimant
Roll, et al., Claimant's Attorneys
Schwabe, et al., Defense Attorneys

WCB 86-08980
January 29, 1988
Order on Review

Reviewed by Board Members Ferris and Crider.

The insurer requests review of those portions of Referee Leahy's order that: (1) awarded claimant 20 percent (64 degrees) unscheduled permanent disability for a back condition, in lieu of a Determination Order that awarded no permanent disability; (2) set aside a denial of breast reduction surgery; and (3) awarded claimant's attorney a $1,500 attorney fee for overturning the aforementioned denial. The issues are extent of unscheduled permanent disability, medical services, and attorney fees.

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

On the medical services issue, the insurer argues that expenses for breast reduction surgery are not compensable under ORS 656.245(1). We disagree.

In Van Blokland v. Oregon Health Sciences University, 87 Or App 694 (1987), the claimant suffered from obesity, which complicated her recovery from compensable left knee and low back surgeries. The medical experts agreed that a weight loss program would assist the claimant in recovering from her compensable injuries, as well as avoid further surgery. In holding that the expenses of a weight loss program were compensable under ORS 656.245(1), the Van Blokland court stated, inter alia:

> "Claimant is entitled to treatment for the disabling results of a compensable injury, even if pre-existing and continuing obesity contributes to the disability. [citations omitted]. The compensable injury need not be the sole cause or the most significant cause of the need for treatment, but only a material contributing cause."

Here, claimant's oversized breasts complicated her recovery from a compensable back injury. As in Van Blokland, the medical experts agreed that the contested medical treatment (i.e., breast reduction surgery) would assist claimant in recovering from her compensable injury. Accordingly, after our de novo review of the lay and medical evidence, we find that the breast reduction surgery is a compensable medical treatment.

Furthermore, we find that the extent of disability and medical services issues present questions of ordinary difficulty with the usual probability of success for claimant on Board review. Consequently, a reasonable attorney fee is awarded.

ORDER

The Referee's order dated February 19, 1987, is affirmed. Claimant's attorney is awarded $500 for services on Board review, to be paid by the insurer.

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

WCB 85-02203
January 29, 1988
Order on Reconsideration

The insurer has requested reconsideration of the Board's Order on Review (Remanding) dated October 12, 1987, which found that the Referee had incorrectly refused to admit into evidence Exhibit 78, a vocational report, properly offered under a former version of OAR 438-07-005(3)(b). On November 4, 1987, the Board's order was abated and claimant was granted an opportunity to respond. Having received claimant's response, the Board has reconsidered the matter.

In our view, the Referee did not have discretion to exclude Exhibit 78 when the technical requirements of OAR 438-07-005(3)(b) had been satisfied. The Referee did not exclude it. Exhibit 78 was initially received in evidence. However, the Referee has discretion to complete the record by means of a postponement or continuance. See ORS 656.283(7). Here, the Referee chose the method of a continuance. When so apprised, claimant voluntarily "withdrew" the document to avoid postponement. Given these facts, Exhibit 78 should not have been received in the record under claimant's "provisional offer" under the Rule. There is no cause to remand the case to the Hearings Division. See ORS 656.295(5). Accordingly, claimant's request for remand is denied.

On reconsideration, the Board withdraws its former order and affirms the order of the Referee, effective this date.

ORDER

The Referee's order dated October 31, 1986, is affirmed.

Claimant has requested reconsideration of that portion of the Board's Order on Review dated October 19, 1987, which affirmed the Referee's finding that he was not a regularly employed worker. On November 13, 1987, the Board's order was abated and the formerly self-insured employer was granted an opportunity to respond. Having received the employer's response, the Board has reconsidered the matter.

Claimant sustained a compensable left wrist injury in April 1985. As a result, he was apparently unable to work and the employer began paying temporary total disability benefits. The "801" claim form provides that claimant worked eight and one-half hours a day, at $5.98 an hour, Monday through Friday. In fact, claimant's hours varied from 40 to 96 hours biweekly and the parties stipulated that his hourly wage was $6.08.

The employer's claims' manager testified that claimant was initially paid temporary total disability benefits at a rate of $174.43 a week. This rate was based on information contained in the 801 form. Later, the manager discovered that payroll records indicated claimant had not actually been paid for 42 1/2 hours in each of the pay periods in 1985. Without investigating the reason for the less-than-anticipated hours of work, the service provider concluded that it was overpaying claimant's temporary total disability benefits, and reduced claimant's benefits to $152.47 a week beginning July 1986. This reduced rate was based on claimant's gross earnings for the 26 weeks preceeding his injury.

The Referee found that temporary total disability benefits should have been paid at a rate based on claimant's "varied" work hours pursuant to OAR 436-60-020(4)(c). On review and in his request for reconsideration, claimant argues that he is "regularly employed" within the meaning of ORS 656.210(2) and that, therefore, OAR 436-60-020(4)(c) is not applicable. On reconsideration, we agree.

ORS 656.210 outlines the method of temporary total disability payment for "regularly employed" workers and provides, inter alia:

> "(2) "'[R]egularly employed' means actual employment or availability for such employment. For workers not regularly employed and for workers with no remuneration or whose remuneration is not based solely upon daily or weekly wages, the director, by rule, may prescribe methods for establishing the worker's weekly wage." (Emphasis added).

The above emphasized language makes it clear that a worker who is "available" for regular employment, is "regularly employed." Here, according to the employer's 801 form, claimant was expected to be available to work for 42 1/2 hours per week, Monday through Friday. His rate of temporary disability benefits should, therefore, be based on a regular 42 1/2 work week pursuant to ORS 656.210(2). Eldon Britt, 32 Van Natta 141 (1981).

Moreover, OAR 436-60-020(4), et seq., applies only to workers employed with "unscheduled, irregular or no earnings . . . ." Here, claimant's earnings were based on the amount of hours he worked biweekly. Those hours varied. Nonetheless, he was employed to work on a regularly scheduled basis. Under such circumstances, we find that claimant is not covered under OAR 436-60-020(4)(c).

After our de novo review, we find that claimant was "regularly employed" pursuant to ORS 656.210(2). See Saiville v. EBI Companies, 81 Or App 469, 472 (1986); Robert T. Moon, 39 Van Natta 370, 371 (1987). Accordingly, our October 19, 1987 order is withdrawn and replaced by this Order on Reconsideration.

ORDER

The Referee's order dated December 17, 1986 is reversed in part and affirmed in part. That portion of the Referee's order directing the rate of claimant's temporary total disability benefits to be calculated pursuant to OAR 436-60-020(4)(c) is reversed. The formerly self-insured employer is directed to calculate claimant's temporary total disability benefits based on a 42 1/2-hour work week pursuant to ORS 656.210(2). Claimant's attorney is awarded 25 percent of claimant's increased compensation created by this order, not to exceed $450. The attorney fee is to be paid out of, not in addition to, compensation. All remaining portions of the Referee's order are affirmed.

LAWRENCE M. SULLIVAN, Claimant
Malagon & Moore, Claimant's Attorneys
Davis, Bostwick, et al., Defense Attorneys

WCB 82-10103
January 29, 1988
Order on Remand

This matter is before the Board on remand from the Court of Appeals. Sullivan v. Banister Pipeline AM, 86 Or App 334 (1987). The court has mandated that claimant's aggravation claim for hospitalization and treatment resulting from his October 6, 1983 attempted suicide be accepted.

Accordingly, the insurer's November 23, 1983 denial is set aside and the claim is remanded to the insurer for processing according to law.

IT IS SO ORDERED.

JOSE YBARRA, Claimant
Francesconi & Cash, Claimant's Attorneys
Rankin, et al., Defense Attorneys

WCB 86-08841
January 29, 1988
Amended Order on Review

The self-insured employer's counsel seeks Board authorization of a client-paid fee for services apparently rendered subsequent to our January 7, 1988 Order on Review. Pursuant to our prior order, we reversed the Referee's compensability finding concerning claimant's aggravation and medical services claims for his current low back condition.

After review of the statement of services and attorney retainer agreement submitted by the employer's counsel and considering the factors set forth in OAR 438-15-010(6), we approve a client-paid fee, not to exceed $59.50.

Except as supplemented herein, we adhere to our January 7, 1988 order in its entirety. The parties' rights of appeal shall continue to run from the date of our prior order.

IT IS SO ORDERED.

YVONNDA M. KENTNER, Claimant
Philip H. Garrow, Claimant's Attorney
Brian L. Pocock, Defense Attorney

WCB 86-09790
February 9, 1988
Order of Dismissal

Claimant has moved the Board for an order dismissing the self-insured employer's request for Board review on the ground that it was untimely filed. The motion is granted.

The Referee's order issued December 14, 1987. The employer mailed a request for Board review on January 14, 1988. A certificate of service, submitted with the request, indicated that copies of the request had been mailed to all parties to the proceeding on January 14, 1988. The Board received the request, which was neither mailed by registered nor certified mail, on January 15, 1988. See OAR 438-05-046(1)(b).

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

Here, the request for review was mailed to the Board and the parties on January 14, 1988, more than 30 days from the date of the Referee's December 14, 1987 order. Under these circumstances, we lack jurisdiction to review the Referee's order, which has become final by operation of law. See ORS 656.289(3); 656.295(2); Argonaut Insurance Co. v. King, supra. Accordingly, the request for Board review is dismissed.

IT IS SO ORDERED.

The Beneficiaries of
DONALD R. STACY (Deceased), Claimant
Lucas & Associates, Claimant's Attorneys
Lester R. Huntsinger (SAIF), Defense Attorney

WCB 87-10911
February 9, 1988
Order of Dismissal

Claimant has requested review of the Referee's order dated December 15, 1987. Claimant's request, dated January 13, 1988, was received by the Board on January 15, 1988. The request was neither mailed by registered or certified mail. A certificate of service, submitted with the request, indicated that copies of the request had been mailed to all parties to the proceeding.

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

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

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

Here, claimant's request for Board review of the Referee's December 15, 1987 order was neither mailed by registered nor certified mail. Since the request was actually received by the Board on January 15, 1988, after the date for filing, it is presumed to be untimely until claimant establishes that the mailing was timely. See OAR 438-05-046(1)(b).

Under these circumstances, we lack jurisdiction to review the Referee's order. Accordingly, the request for Board review is dismissed.

IT IS SO ORDERED.

SHIRLEY A. BRITT, Claimant
Malagon & Moore, Claimant's Attorneys
Paul Roess, Defense Attorney

WCB 86-05940
February 10, 1988
Order on Reconsideration

The self-insured employer has requested reconsideration of the Board's Order on Review dated September 18, 1987. It protests the Board's designation of the compensable condition as "a lumbar strain with associated nerve root irritation affecting the legs." It also submits a post-hearing medical report and requests that the Board remand the case to the Referee for further proceedings. We abated our order to allow sufficient time to consider the request.

With regard to the employer's request for remand, the employer submits a one-paragraph report dated March 9, 1987 authored by Dr. Jones, a consulting neurologist. In the report, Dr. Jones states that he had not seen claimant since April of 1986 and then proceeds to give his opinion regarding the etiology of her condition. The hearing before the Referee was held in October 1986, several months after Dr. Jones' last contact with claimant. In view of these facts, the report could have been secured prior to the hearing with the exercise of due diligence. We conclude, therefore, that remand is not appropriate. See Bernard L. Osburn, 37 Van Natta 1054, 1055 (1985); aff'd mem., 80 Or App 152 (1986).

We thus turn to the employer's request that we alter our designation of the compensable condition. In her order, the Referee recited evidence concerning pains claimant was experiencing in her legs and also mentioned a diagnosis by Dr. Jones of a back strain. The Referee, however, did not directly state that the two problems were related. In its brief on Board review, the employer argued that the Referee had erred in setting aside its denial of claimant's leg problems because there was no

consensus in the record regarding the precise nature or etiology of these problems. We reviewed the record and, based upon reports by Dr. Vancho, the treating chiropractor, and Dr. Jones, the consulting neurologist, concluded that the most likely diagnosis was a lumbar strain with associated nerve root irritation affecting the legs. The employer contends that this designation of the compensable condition was "contrary to the overwhelming weight of the evidence" and requests that we redesignate the condition simply as "a problem with claimant's right lower extremity."

The evidence supports a diagnosis of a lumbar strain. It also supports the conclusion that claimant experiences pain in both legs, worse on the right, and that this pain was caused by her work activity. The etiology of her leg pain admittedly is a matter of medical controversy. We adhere to our conclusion that claimant's lumbar strain and her bilateral leg difficulties are compensable. After reconsideration, however, we agree with the employer that our finding of nerve root irritation was speculative and hereby withdraw that portion of our order that designated nerve root irritation as the cause of claimant's leg problems. We thus leave the precise etiology of claimant's leg problems unspecified. As modified herein, we adhere to and republish our previous order, effective this date.

IT IS SO ORDERED.

EMMA J. FENTON, Claimant
Pozzi, et al., Claimant's Attorneys
Foss, Whitty & Roess, Defense Attorneys

WCB 84-02176
February 10, 1988
Order on Remand

This matter is before the Board on remand from the Court of Appeals. Fenton v. SAIF, 87 Or App 78 (1987). The court has concluded that claimant's May 3, 1982 neck injury is a direct and natural consequence of her February 2, 1982 compensable back injury. Consequently, the neck injury has been found to be compensable.

Accordingly, the SAIF Corporation's October 29, 1984 partial denial is set aside and claimant's neck injury claim is remanded to SAIF for processing according to law.

IT IS SO ORDERED.

TIMOTHY W. GREGORY, Claimant
Glenn T. Okawa, Claimant's Attorney
Roberts, et al., Defense Attorneys

WCB TP-87023
February 10, 1988
Third Party Order

Claimant has petitioned the Board to resolve a dispute concerning the validity of the insurer's lien as paying agency against the proceeds from his recent circuit court judgment. The judgment resulted from claimant's cause of action for negligence stemming from a motor vehicle accident. We consider this dispute to determine whether the aforementioned judgment is subject to the third party statutes. See ORS 656.576 to 656.595.

In December 1982 claimant was injured when the car he was operating was struck by another motor vehicle. There is no contention that this accident was compensable. Claimant sought treatment from Dr. Rogosin, complaining of left hip and rib cage pain. His condition was diagnosed as a left hip contusion, with perhaps a bruise to the left side and ribs. Treatment consisted of rest, warm compresses, and medication.

In February 1983 claimant began treating with Dr. Dahlstrom, chiropractor. Although his rib pain was subsiding, claimant complained of progressively increasing mid-back pain. Dr. Dahlstrom treated claimant for "mild, though chronic" mid-back pain and, eventually, released him "without impairment and asymptomatic."

In February 1984 claimant filed a workers' compensation claim for "back pain." He described the injury as occurring while he was performing his work duties as a custodian. i.e., mopping. Claimant returned to Dr. Dahlstrom, where his condition was diagnosed as intercostal neuralgia, thoraco-lumbar sprain, and subluxation. Stating that claimant was asymptomatic from the injuries of the December 1982 auto accident, Dr. Dahlstrom related his condition to the work incident. The claim was accepted.

In June 1984 Dr. Dahlstrom reported that claimant was keeping his appointments for palliative care to maintain his medically stationary condition. Shortly thereafter, the claim was closed, by Notice of Closure, with one day of time loss paid. This notice was subsequently affirmed by the Evaluation Division.

In March 1985 Dr. Dahlstrom opined that claimant's industrial accident had resulted in the reinjury of many of the same areas that had been injured in the December 1982 auto accident. Although he had anticipated an early resolution to the effects of the industrial accident, Dr. Dahlstrom stated that claimant's mid-back injury had proven resistant to treatment. Yet, Dr. Dahlstrom noted that claimant was now receiving treatment on an "as needed basis," which was less than once a month. Given those circumstances, Dr. Dahlstrom was hesitant to conclude that claimant's injury was permanent in nature.

In May 1985 Dr. Bolin, chiropractor, performed an independent medical examination. Reporting that he was receiving between one and three treatments per month for his mid-thoracic back pain, claimant believed that his condition had returned to its "pre-industrial injury" status. Based on claimant's history, Dr. Bolin concluded that claimant had suffered a cervicothoracic injury in the December 1982 automobile accident. In Dr. Bolin's opinion, claimant's mid-thoracic spine had been temporarily aggravated by the February 1984 industrial injury. Attributing claimant's current symptoms and need for medical treatment to the December 1982 automobile injury and not the February 1984 compensable injury, Dr. Bolin concluded that claimant's condition was medically stationary without permanent impairment from either injury.

Dr. Dahlstrom agreed with Dr. Bolin's exam findings with one supplementation. Dr. Dahlstrom included a diagnosis of mild and chronic thoracic disc disorder, which had been initially injured in claimant's automobile accident and later reinjured at work.

In June 1985 the insurer issued a partial denial, contending that claimant's current condition was not related to his February 1984 compensable claim. Rather, it asserted that claimant's current condition was related to the December 1982 auto accident. Claimant requested a hearing concerning this denial, "to the extent the Carrier is claiming lien against settlement of auto accident dated 12/22/82 per ORS 656.587-593 [sic]."

Following the submission of his petition to the Board for resolution of the "third party" dispute, claimant withdrew this hearing request.

Sometime after the December 1982 auto accident, claimant initiated a cause of action for negligence against the driver of the other vehicle. In May 1987, at the request of the other driver's insurer, Dr. Bolin performed another examination. Attributing claimant's lower cervical and mid-thoracic spine problems to "trauma," Dr. Bolin opined that this "trauma" had resulted in "quite minimal" permanent impairment.

In June 1987 a jury found the driver of the other vehicle 80 percent negligent in causing the accident. Accordingly, claimant received a judgment of $6,000 general damages, no special damages, and $330.50 in costs and disbursements.

Pursuant to ORS 656.154, 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. 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. The proceeds of any damages recovered from a third person by the worker shall be subject to a lien of the paying agency for its share of the proceeds. ORS 656.593.

The insurer asserts a third party lien of $2,645.62, which is composed of $1,845.62 in actual claim costs and $800 in future expenditures. After providing for claimant's attorney's fee, litigation costs, and the 1/3 statutory share pursuant to ORS 656.593(1)(b), the insurer submits that the remaining balance of the judgment would equal $2,667.33. Upon application of this balance to its lien, the insurer suggests that claimant receive the remaining portion of the judgment. ($21.05).

Contending that the judgment is entirely attributable to the noncompensable automobile accident and not his compensable injury, claimant objects to the insurer's assertion of a third party lien. We agree and find that the judgment is not subject to the third party statutes.

As previously stated, the proceeds of any damages recovered by a worker from a third person are subject to an insurer's lien as paying agency. See ORS 656.593. However, this provision is expressly contingent upon the worker having received a compensable injury due to the negligence or wrong of the third person. See ORS 656.154; 656.578. Here, there is no contention that the December 1982 auto accident was compensable. Thus, any and all recovered damages resulting from this accident are not subject to the aforementioned statutory provisions.

The insurer's lien against the proceeds of claimant's judgment is primarily based on two points. First, that the February 1984 compensable mopping incident reinjured many of the areas initially injured in the December 1982 noncompensable auto accident. Secondly, that an undisclosed portion of the medical treatments for which the insurer has previously incurred expenses were attributable to the auto accident.

There is some support for each of these points. Yet, the points are rendered meaningless by remaining portions of the record. Specifically, these remaining portions include: (1) the insurer's June 1985 denial of responsibility for claimant's current condition, which has become final by operation of law; and (2) the judgment itself.

Finally, even assuming that the insurer was entitled to a portion of the proceeds from the judgment, the record does not establish its entitlement to a lien for future expenditures. After review of this record, including consideration of the insurer's partial denial, we are not persuaded that it is reasonably certain that claimant will require future medical services as a result of his compensable injury. See Leonard Henderson, 40 Van Natta 31 (January 21, 1988); Robert T. Gerlach, 36 Van Natta 293, 297 (1984).

Based on the foregoing reasoning, we hold that the insurer is not entitled to a lien against any portion of claimant's judgment. Accordingly, claimant may distribute the proceeds of the judgment unencumbered by any restrictions set forth in ORS 656.593.

IT IS SO ORDERED.

TOMMY L. TRONSON, Claimant
Ginsburg, et al., Claimant's Attorneys
David B. Smith (SAIF), Defense Attorney

WCB 87-11240
February 10, 1988
Order of Dismissal

The SAIF Corporation has requested review of Referee Mulder's order dated December 30, 1987. SAIF's request, dated January 29, 1988, was received by the Board on February 1, 1988. The request was neither mailed by registered nor certified mail. A certificate of service, submitted with the request, indicated that copies of the request had been mailed to all parties to the proceeding.

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

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

Here, SAIF's January 29, 1988 request for Board review of the Referee's December 30, 1987 order was neither mailed by registered nor certified mail. Since the request was actually received by the Board on February 1, 1988, after the date for

filing, it is presumed to be untimely until SAIF establishes that the mailing was timely. See OAR 438-05-046(1)(b).

Under these circumstances, we lack jurisdiction to review the Referee's order. Accordingly, the request for Board review is dismissed.

IT IS SO ORDERED.

ERNEST F. ERCK, Claimant
Pozzi, et al., Claimant's Attorneys
Beers, et al., Defense Attorneys

WCB 86-05134
February 11, 1988
Order on Review

Reviewed by Board Members Ferris and Johnson.

The insurer requests review of Referee St. Martin's order that granted claimant an award of permanent total disability in connection with his lung condition in lieu of an award by Determination Order of 30 percent (96 degrees) unscheduled permanent partial disability. The issue is extent of permanent disability, including permanent total disability.

Claimant filed a claim in May 1984 for asthma allegedly due to his exposure to isocyanates in the course of his employment for 35 years as an auto body painter. The claim was found compensable by Opinion and Order in January 1985. Claimant treated with Dr. Noonan, an allergy and asthma specialist, and was given medications for his condition. Dr. Noonan indicated that claimant was medically stationary in October 1985 and reported that claimant had lost most of his lung capacity. He nonetheless stated that claimant was capable of light work on a full-time basis in an environment free of paint fumes and other pollutants. The claim was closed by Determination Order in February 1986 with a 30 percent unscheduled award.

Claimant received vocational assistance in late 1985 and early 1986. At the initial meeting, claimant indicated that he could perform basically any job which did not involve sustained heavy activity or closed environments with smoke or fumes. Thereafter, the vocational counselor attempted to develop a return-to-work plan, but claimant did not maintain contact with her or return her calls. In February 1986, the counselor sent claimant a letter warning him that failure to participate could result in the termination of vocational services. Claimant's attorney replied to the letter, stating that claimant did not understand how vocational services would help him, but that he was willing to cooperate. After this, the counselor attempted to contact claimant on a number of occasions, but received no reply. Vocational assistance was terminated in April 1986 on the ground that claimant had not participated in developing a return-to-work plan. Claimant did not protest or appeal the termination of vocational services.

At the hearing, claimant testified that he experienced difficulty breathing when he exerts himself, when he is under stress and when he is exposed to cold weather, smoke or fumes. His condition was controlled with medication. He indicated that after the compensability of his claim was denied by the employer in June 1984, he had applied for employment at a number of businesses in connection with a claim for unemployment benefits. Since that time, however, he had not sought employment. He explained his lack of participation in vocational rehabilitation efforts as due to his reserved and noncommunicative personality and felt that the vocational counselor's efforts had been minimal.

The vocational counselor recounted her efforts in attempting to contact claimant and get him involved in a return-to-work plan. Based on the information she had received and the limited contact that she had achieved, she opined that claimant was employable in the light category in a number of gainful occupations including assembly line work, cashiering, bicycle repair, shuttle driving, truck driving and janitorial work.

Claimant was 62 years old at the time of the hearing and has a ninth grade education. His entire adult work history was in the area of autobody painting.

The Referee granted claimant an award of permanent total disability. He found that claimant had participated in vocational rehabilitation efforts "as far as he was able" and suggested that in light of claimant's lung impairment, age, lack of education and limited work experience, vocational assistance efforts would have been futile.

We disagree with the Referee's analysis. Claimant's treating doctor indicated that he was capable of light work on a full-time basis. The vocational counselor who attempted to help him opined that he was employable. Although there is evidence that claimant is reserved and noncommunicative, there is no indication that these difficulties were so severe as to excuse claimant's failure to maintain contact with the vocational counselor. He had no apparent difficulty communicating with his doctors or at the hearing. We conclude that claimant, in essence, refused vocational assistance and that he has failed to establish that he is willing to seek regular gainful employment or that he has made reasonable efforts to obtain such employment. ORS 656.206(3). He, therefore, is not entitled to an award of permanent total disability.

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

Following our de novo review of the medical and lay evidence and exercising our independent judgment in light of claimant's impairment and the relevant social and vocational factors, we conclude that an award of 240 degrees for 75 percent unscheduled permanent partial disability adequately and appropriately compensates claimant for the permanent loss of earning capacity due to the compensable occupational disease. We grant this award in lieu of all previous awards. No offset for compensation paid pursuant to the Referee's award of permanent total disability may be authorized. United Medical Laboratories v. Bohnke, 81 Or App 144, 146 (1986).

ORDER

The Referee's order dated March 13, 1987 is reversed. In addition to the 30 percent (96 degrees) unscheduled permanent disability awarded by the Determination Order, claimant is awarded 45 percent (144 degrees) unscheduled permanent partial disability for his compensable lung condition. Claimant's attorney fee shall be adjusted accordingly.

ROBERT D. JACKSON, Claimant
Tooze, Marshall, et al., Defense Attorneys

WCB 85-08850
February 11, 1988
Order on Review

Reviewed by Board Members Ferris and Crider.

Claimant, pro se, requests review of those portions of Referee Brown's order that: (1) declined to set aside all prior Determination Orders as "illegal"; (2) declined to award additional temporary disability benefits; (3) upheld the insurer's "de facto" denial of his alleged psychiatric condition; (4) declined to award increased unscheduled permanent disability for a back condition, beyond a prior award of 60 percent (192 degrees) by way of two Determination Orders and a stipulation; (5) declined to grant permanent total disability; and (6) declined to assess a penalty for "illegal" closure of his claim. The insurer cross-requests review of that portion of the order that set aside its "de facto" denial of vocational services. In addition, the insurer has moved the Board to strike those portions of claimant's brief, which support a request for Board review. The threshold issue is whether claimant's request for review should be dismissed. The remaining issues are the legality of the Determination Order, penalties, compensability, permanent total disability, extent of unscheduled permanent disability, and vocational services.

The Board finds no cause to strike any portions of claimant's brief or to dismiss his request for review. Both parties have requested Board review. The insurer has not withdrawn its request for review, which we expressly acknowledged on April 27, 1987, as a "cross-request" for review. Accordingly, on de novo review, we may review all issues raised or raisable on the entire record presently before us. Destael v. Nicolai Co., 80 Or App 596, 600-01 (1986); Russell v. A & D Terminals, 50 Or App 27, 31 (1981).

Turning to the merits, the Board reverses on the vocational services issue, but affirms all remaining portions of the Referee's order.

In June 1985, Dr. Campagna, claimant's treating neurosurgeon, stated in a chart note that claimant "will be referred to the Callahan's [sic] Center for vocational rehabilitation." A few months later, Campagna's secretary signed a letter to claimant stating, inter alia: "Dr. [Campagna] has reviewed your medical reports extensively and it is his considered medical opinion to recommend vocational rehabilitation." Finding that Campagna had recommended vocational rehabilitation, the Referee set aside the insurer's "de facto" denial of vocational services. We disagree.

ORS 656.283(2) provides, in part:

> "If a worker is dissatisfied with an action of the insurer or self-insured employer or the department regarding vocational assistance, the worker must first apply to the director for administrative review of the matter before requesting a hearing on that matter." (Emphasis added).

Here, claimant did not first apply to the director for administrative review before requesting a hearing. Accordingly, the Hearings' Division had no jurisdiction to consider the vocational services matter.

ORDER

The Referee's order dated March 20, 1987 is reversed in part and affirmed in part. That portion of the Referee's order that set aside the insurer's "de facto" denial of vocational services is reversed. All remaining portions of the Referee's order are affirmed.

ROBERT S. NEELAND, Claimant
Richardson, et al., Claimant's Attorneys
Roberts, et al., Defense Attorneys
Rankin, VavRosky, et al., Defense Attorneys

Own Motion 86-0154M, 86-0155M & 86-0156M
February 11, 1988
Own Motion Order

Claimant has requested that the Board exercise its Own Motion authority pursuant to ORS 656.278 and find his hearing loss claims compensable. The Board finds that it lacks jurisdiction to grant the request.

The relevant facts are not in dispute. In February 1983 claimant requested a hearing. At issue was the compensability of his hearing loss claim against several Oregon employers. Claimant also filed a claim with the Labor & Industries Department in the State of Washington. In February 1985 and in November 1985, the cases were placed in inactive status, pending the outcome of claimant's hearing loss claim in Washington.

On November 25, 1985, claimant's counsel notified the Board that claimant had reached a settlement concerning his Washington claim. Consequently, he was withdrawing his requests for hearing. Pursuant to December 11, 1985 Orders of Dismissal, the hearing requests were dismissed.

On February 18, 1986, claimant moved to reinstate his requests for hearing. The motion was based on claimant's counsel's understanding that the State of Washington had decided to deny responsibility for claimant's hearing loss claim.

On March 7, 1986, the Presiding Referee denied claimant's motion. Inasmuch as the December 11, 1985 dismissal orders had neither been appealed, abated, or reconsidered within the statutory 30-day period, the Referee concluded that they had become final. Accordingly, the Referee found that the Hearings Division lacked jurisdiction to consider claimant's request. However, the Referee submitted the matter to the Board for consideration pursuant to its Own Motion authority.

On April 7, 1986, the State of Washington formally rejected claimant's hearing loss claim. Claimant appealed the decision. However, on July 13, 1987, he withdrew his appeal and the matter was dismissed.

In support of his request for Own Motion relief, claimant cites Alberto V. Monaco, 39 Van Natta 337 (1987). In Monaco, we relied on the rationale expressed in Miville v. SAIF, 76 Or App 603 (1985), and stated that an Oregon insurer remains responsible for a subsequent out-of-state injury when the claimant has filed a claim in the foreign jurisdiction and the claim has been "finally determined" to be noncompensable. We further held that a failure to appeal a denial results in a "final" determination of the claim.

Here, as in Monaco, there has been a "final determination" in a foreign jurisdiction that an out-of-state claim is not

compensable. However, the present situation is distinguishable from Monaco in several significant respects. To begin, unlike Monaco, no Oregon insurer has ever accepted, or been found responsible, for claimant's hearing loss claim. Thus, because no previously compensable Oregon claim exists, the responsibility analysis described in Miville and Monaco cannot be applied.

Moreover, the current petition for relief concerns the ultimate contention that, at a minimum, one of claimant's hearing loss claims with an Oregon employer is compensable. Yet, in order to grant such a request, we would be required to set aside the Referee's dismissal orders. Implicit with the issuance of the dismissal orders is the conclusion that claimant no longer raised the issues asserted in his requests for hearing. In other words, claimant withdrew his contention that his hearing loss claims with the Oregon employers were compensable.

Inasmuch as the orders of dismissal were neither appealed, abated, modified, nor republished within 30 days of their issuance, they have become final by operation of law. ORS 656.289(3). Therefore, were we to grant claimant's request, set aside these final orders, and consider the compensability/responsibility question, we would be modifying, changing, or terminating a former finding or order that claimant incurred no injury or incurred a noncompensable injury. Such an action would exceed our statutory authority. See ORS 656.278(5)(a).

Based on the foregoing reasoning, we conclude that we lack authority to grant the relief requested by claimant's petition. Accordingly, the request for Own Motion relief is denied.

IT IS SO ORDERED.

ALLEN W. NELSON, Claimant
Black, et al., Claimant's Attorneys
Cowling & Heysell, Defense Attorneys
SAIF Corp Legal, Defense Attorney

WCB 86-15611 & 87-04121
February 11, 1988
Order on Review

Reviewed by Board Members Ferris and Johnson.

Gates McDonald & Company requests review of those portions of Referee Brown's order that: (1) set aside its aggravation and medical services denial for a low back condition; and (2) upheld the SAIF Corporation's occupational disease denial for the same condition. Claimant cross-requests review of apparently that portion of the order that awarded an attorney fee payable out of his compensation. Inasmuch as claimant's aggravation rights were in own motion status at the time of hearing, the threshold issue on review is whether the Referee had jurisdiction to consider whether claimant had sustained an aggravation. The remaining issues are responsibility for claimant's medical services and attorney fees.

Claimant, 36 at hearing, initially injured his low back in April 1976, while working as a refrigerator mechanic for Chef Francisco. The claim was accepted by SAIF and resulted in a few weeks of temporary disability payments. Thereafter, Chef Francisco apparently changed insurers and began coverage with Gates McDonald.

In October 1977, claimant compensably reinjured his low back while still employed at Chef Francisco. His condition was

diagnosed as a lumbar strain accompanied by degenerative disc disease. Gates McDonald eventually accepted the condition as a new injury.

Although claimant continued to experience low back and bilateral leg pain, he returned to his regular work in March 1978. A Determination Order closed the claim on July 30, 1979, with an award of 10 percent unscheduled permanent disability. The award was later increased to a total of 20 percent by stipulation.

In 1978 or 1979, claimant stopped working as a refrigerator mechanic and began selling real estate. He later worked as a pool cleaner, carpenter, and baker. In January 1984, he was employed by SAIF's insured as a security guard. The job required claimant to walk on hard surfaces. Claimant credibly testified that his low back symptoms had not fully resolved prior to his employment as a security guard. Thereafter, his symptoms gradually increased until October 1985, when he could no longer perform his job.

In January 1986, claimant was reexamined by Dr. Towne, chiropractor, whom he had seen on previous occasions. Towne opined:

> "It has become apparent that [claimant] had continued to experience recurring low back pain between his last visit on March 18, 1983, to the date of re-presentation on November 7, 1984."
>
> "In the absence of significant trauma, it is my opinion that this represents an exacerbation of progressive worsening of the patient's original [October 1977] low back injury . . . ."

In May 1986, claimant was involved in an off-the-job automobile accident. He reported to a hospital with complaints of left shoulder and low back pain. According to claimant, he experienced an increase in symptoms for only two to four weeks. Thereafter, his symptoms returned to their previous level.

In the fall of 1986, a myelogram and CT scan revealed a disc protrusion at L4-5. Finding that claimant needed lumbar diskectomy surgery, Dr. Campagna, neurosurgeon, requested Gates McDonald to reopen claimant's October 1977 claim. In October 1986, Gates McDonald denied responsibility for claimant's "current time loss and treatment."

Shortly thereafter, claimant was examined by Dr. Mathews, orthopedist. Mathews felt that "the biggest cause" of claimant's disc protrusion was a gradual degenerative process. Mathews also stated that the October 1977 injury "seems to account for some part" of claimant's symptomatology.

In December 1986, Dr. Campagna reported that claimant's herniated disc was "secondary to [the] industrial injury of [October] 1977." Shortly thereafter, claimant underwent diskectomy surgery. Following the surgery, Campagna opined that it was "in the realm of possibility" that claimant's work activities after 1984 had contributed to his disc protrusion.

In February 1987, claimant filed an occupational disease claim against SAIF, alleging that his work activities after 1984 worsened his preexisting back problems. Although SAIF denied responsibility for claimant's low back condition, it conceded that his condition was "work related."

A few months later, claimant was examined by Dr. Affley, physician. According to Affley, claimant's employments from 1981 through 1986 "independently contributed to some extent to the worsening of the pathologic process . . . ."

At the hearing, Gates McDonald's attorney conceded the the issue of compensability:

> "REFEREE: [Y]ou know what the question I'm going to ask is. You're denying responsibility -- not compensability?"
>
> "[ATTORNEY]: That's essentially [Gates McDonald's] position -- that it's a Denial of responsibility. I should note that the claimant is in Own Motion jurisdiction."

At the time of hearing, claimant had not requested own motion relief from the Board.

The Referee found that claimant had suffered an aggravation, rather than a "new injury." The Referee, therefore, set aside Gates McDonald's October 1986 denial in its entirety. In addition, the Referee awarded claimant's attorney an attorney fee, payable out of compensation, for temporary total disability benefits and any future increased permanent partial disability benefits. We disagree.

ORS 656.273(4)(a) provides:

> "Except as provided in paragraphs (b) and (c) of this subsection, the claim for aggravation must be filed within five years after the first determination made under ORS 656.268(4)."

Here, claimant sustained a low back injury in October 1977, which was accepted by Gates McDonald as a disabling injury. On July 30, 1979, the Evaluation Division closed the claim by way of a Determination Order that awarded claimant 10 percent unscheduled permanent disability. Pursuant to ORS 656.273(4)(a), claimant had five years from July 30, 1979, to file an aggravation claim. Claimant did not do so; his aggravation claim was not filed until September 1986. Consequently, the Referee lacked jurisdiction to consider whether claimant had sustained an aggravation.

Unlike the aggravation issue, however, the Referee retained jurisdiction over the medical services issue. That is, the duty of an insurer to provide compensable medical services "continues for the life of the worker." ORS 656.245(1).

Inasmuch as both insurers conceded the compensability of claimant's current need for medical services, we need only address the matter of responsibility. In Hensel Phelps Construction v. Mirich, 81 Or App 290, 294 (1986), the court announced that unless the first insurer proved that the "new injury" independently

contributed to the worker's disability (i.e., caused a worsening of his underlying condition), it remained responsible.

Here, Drs. Towne, Mathews, and Campagna all opined that claimant's current condition was related to his October 1977 injury. Dr. Affley was the only doctor who stated, in terms of a reasonable medical probability, that claimant's work activities at SAIF's insured independently contributed to his current condition. Yet, unlike Towne, Affley did not observe claimant until well after his condition began to deteriorate beginning in 1984. Therefore, Affley had little basis for a comparison with claimant's previous condition. Kienow Food Stores v. Lyster, 79 Or App 416, 421 (1986). In sum, we are persuaded by the collective opinions of Drs. Towne, Mathews, and Campagna. Accordingly, we conclude that Gates McDonald is responsible for claimant's current low back condition and resulting need for medical services.

Lastly, we turn to the issue of attorney fees. The Referee awarded claimant's attorney an attorney fee payable out of claimant's compensation. See Mark L. Queener, 38 Van Natta 882 (1986). Here, there was no ORS 656.307 order and claimant's right to compensation remained at issue until Gates McDonald conceded the issue of compensability at hearing. Under such circumstances, we find that claimant's attorney should have been awarded a reasonable insurer-paid attorney fee for his services at hearing in setting aside that portion of Gates McDonald's denial that pertained to medical services. ORS 656.386(1); See also former OAR 438-47-020(1)(a).

ORDER

The Referee's order is modified in part, reversed in part, and affirmed in part. Gates McDonald & Company's October 1986 denial is set aside insofar as it denied responsibility for claimant's current need for medical services. The remainder of Gates McDonald's denial is upheld. That portion of the Referee's order that awarded temporary total disability is reversed. In lieu of the Referee's award of attorney fees, claimant's attorney is awarded a reasonable attorney fee of $800 for his services at hearing in setting aside Gates McDonald's denial of current medical services, and $500 for his services on Board review. These fees shall be paid by Gates McDonald in addition to, and not out of, claimant's compensation. All remaining portions of the Referee's order are affirmed.

ALLEN W. NELSON, Claimant
Black, et al., Claimant's Attorneys
Cowling & Heysell, Defense Attorneys
SAIF Corp Legal, Defense Attorney

Own Motion 87-0515M
February 11, 1988
Own Motion Order

Claimant has requested that the Board exercise its own motion authority and reopen his claim with Gates McDonald & Company for a 1977 low back injury. Claimant's aggravation rights have expired. On September 14, 1987, the Board deferred acting upon claimant's request since he had requested consolidation with proceedings that were presently pending. (WCB Case Nos. 86-15611 & 87-04121). The hearing concerned, inter alia, the issue of responsibility.

The litigation proceeded to hearing. On July 16, 1987, the Referee found that Gates McDonald remained responsible for

claimant's worsened low back condition. Consequently, the Referee set aside Gates McDonald's denial and ordered it to begin paying temporary total disability benefits.

Gates McDonald requested Board review of the Referee's order. This date, we have modified a portion of the Referee's order. We found that inasmuch as claimant's aggravation rights under his 1977 injury claim had expired under ORS 656.273, the Referee was without jurisdiction to award temporary total disability benefits. However, we affirmed that portion of the order that set aside Gates McDonald's denial of current medical services.

Following our review of the record, we find that claimant's low back condition worsened in September 1986 as a result of his 1977 injury. Claimant was hospitalized on December 2, 1986, for a lumbar diskectomy. Accordingly, the claim should be reopened for the payment of temporary total disability to commence December 2, 1986 and to continue until claimant returns to his regular work at his regular wage or is medically stationary, whichever is earlier. See OAR 438-12-052(2)(c). Reimbursement from the Reopened Claims Reserve is authorized to the extent allowed under ORS 656.625 and OAR 436, Division 45. See OAR 438-12-052(3). When appropriate, the claim shall be closed by the insurer pursuant to OAR 438-12-055. As a reasonable attorney fee, claimant's attorney is awarded 25 percent of the additional compensation granted by this order not to exceed $600.

IT IS SO ORDERD.

MARIA MARTINEZ, Claimant
Ginsburg, et al., Claimant's Attorneys
SAIF Corp Legal, Defense Attorney
Schwabe, et al., Defense Attorneys
Bottini & Bottini, Defense Attorneys

WCB 87-02506, 87-01443 & 87-17747
February 10, 1988
Order Dismissing Request for Review and Remanding

Claimant has requested Board review of Referee Tenenbaum's January 13, 1988 "Order on Motion to Dismiss and Pretrial Order." We have reviewed the request to determine whether the Referee's order is a final order which is subject to review. Zeno T. Idzerda, 38 Van Natta 428 (1986).

The Referee found that claimant's current right hand and arm claims against two of three potentially responsible insurers were barred by the doctrine of res judicata and/or collateral estoppel. Characterizing her order as "interim," the Referee advised the two insurers that they need not appear at a forthcoming hearing. The Referee's order did not contain a statement explaining the parties' rights of appeal pursuant to ORS 656.289(3). The Referee further advised the parties that, following the hearing, the "interim" order would be incorporated into a final order.

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

Here, the Referee's order neither finally disposed of,

nor allowed, the claim. Moreover, the order did not fix the amount of claimant's compensation. Rather, the order was "interim" and advisory in nature. It notified two of the insurers that their appearance at an upcoming hearing was not required and that formal approval of their motions to dismiss would eventually be incorporated into a final, appealable order. A preliminary order such as this is in keeping with the Board's interest in avoiding piecemeal review of multiple issues arising in a single case. See Harris E. Jackson, 35 Van Natta 1674, 1676 (1983).

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

Accordingly, the request for Board review is dismissed and this matter is remanded to Referee Tenenbaum for further proceedings.

IT IS SO ORDERED.

GARY HUNTER, Claimant

Own Motion 87-0735M
February 16, 1988
Own Motion Order

Claimant has requested that the Board exercise its own motion authority and reopen his claim for an alleged worsening of his April 28, 1980 industrial injury. Claimant's aggravation rights have expired. The insurer opposes reopening of this claim for the payment of temporary total disability compensation.

Under the new law, which became effective January 1, 1988, temporary total disability benefits may be allowed only when the injured worker is hospitalized or undergoes surgery. Neither has taken place in this case. The request for own motion relief must be denied.

IT IS SO ORDERED.

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

WCB 86-01069
February 16, 1988
Order on Reconsideration

Claimant requests reconsideration of those portions of the Board's October 8, 1987 Order on Review which: (1) upheld the self-insured employer's denials of his aggravation and medical services claims for his current back condition; and (2) determined that he was not entitled to an award of unscheduled permanent disability. Specifically, claimant contends that his current condition is causally related to his compensable injury and that the Board lacked jurisdiction to consider the extent of his unscheduled permanent disability.

Subsequent to the Board's order, the Court of Appeals stated in Van Blokland v. Oregon Health Sciences University, 87 Or App 694 (1987), that when weight loss is required for a claimant's total medical treatment of a compensable injury, a weight loss program can be a compensable medical service under ORS 656.245(1). The court reiterated its previous holding that a

claimant is entitled to treatment for the disabling results of a compensable injury, even if preexisting and continuing obesity contributes to the disability. See Taylor v. SAIF, 75 Or App 583, 586 (1985).

Here, claimant has experienced preexisting and chronic obesity. His treating chiropractor acknowledges the marked obesity, but continues to relate claimant's current back condition to the 1983 compensable injury. However, as stated in the Board's previous order, the preponderance of the persuasive evidence establishes that claimant's current condition is not related to his compensable injury. Following reconsideration, we agree and continue to find that claimant's current aggravation and medical services claims are not compensable.

The Referee declined to address the extent of unscheduled permanent disability issue because the aggravation claim had been found compensable. Inasmuch as we have upheld the employer's denial of claimant's aggravation claim, the issue of extent has become ripe for decision.

Claimant asserts that we lack jurisdiction to consider the extent issue. We disagree. On de novo review, we are authorized to make any disposition of the case as is deemed appropriate. Destael v. Nicolai Co., 80 Or App 596 (1986). Such disposition can include determining the extent of permanent disability, without first remanding to the Referee, when sufficient evidence in the record exists upon which to determine the issue. David L. Fleming, 38 Van Natta 1321 (1986), aff'd mem Fleming v. Daeuble Logging, 89 Or App 87 (1987); Marco Aguiar, 38 Van Natta 413, 414 (1986), rev'd on other grounds, Aguiar v. J.R. Simplot Co., 87 Or App 475 (1987).

Turning to the merits of this case, we reiterate that the record has not been "improperly, incompletely or otherwise insufficiently developed." See ORS 656.295(3). Therefore, this matter need not be remanded to the Referee for a determination of claimant's permanent disability resulting from his compensable injury.

Finally, following our further review of the medical and lay evidence, we are not persuaded that claimant has sustained a permanent loss of earning capacity due to his compensable injury. See ORS 656.214(5). Consequently, we continue to conclude that claimant is not entitled to an award of unscheduled permanent disability.

Accordingly, the request for reconsideration is granted and our October 8, 1987 order withdrawn. On reconsideration, as supplemented herein, we adhere to and republish our October 8, 1987 order, effective this date.

MARIA MARTINEZ, Claimant
Ginsburg, et al., Claimant's Attorneys
Bottini, et al., Defense Attorneys
Ruth Cinniger (SAIF), Defense Attorney
Schwabe, et al., Defense Attorneys

WCB 85-04637, 86-04133 & 86-05155
February 16, 1988
Order on Review

Reviewed by Board Members Ferris and Johnson.

The SAIF Corporation requests review of those portions of Referee Tenenbaum's order that: (1) set aside its denial of claimant's occupational disease claim for a low back condition; (2) upheld SAFECO Insurance Co.'s denial for the same condition; (3) upheld Leonard J. Russo Co.'s (Russo) aggravation denial for

the same condition; (4) awarded an extraordinary attorney fee; and (5) assessed SAIF a penalty for improper claims processing. Claimant cross-requests review of those portions of the Referee's order that: (1) upheld SAIF's denial of claimant's injury claim for upper back, neck, right arm and headache conditions; (2) upheld SAFECO's denial for the same condition; (3) upheld Russo's denial for the same condition and for continued medical services; and (4) declined to award an insurer-paid attorney fee for SAIF's untimely disclosure of medical documents and alleged unreasonable failure to request the designation of a paying agent. On review, the issues are compensability, responsibility, medical services, penalties and attorney fees.

We reverse that part of the order that declined to assess attorney fees for SAIF's late disclosure of medical documents. We modify that portion of the order that assessed penalties for the unreasonable claims processing. We affirm the remainder of the order.

Claimant compensably injured her low back in January 1983 while working for Russo's insured. Dr. Pace, chiropractor, diagnosed acute lumbosacral strain. Shortly thereafter, claimant was released to return to work with no restrictions. On March 12, 1983, she was found medically stationary with no permanent impairment. Her claim was closed administratively with an award of temporary disability only.

Claimant was employed by AMFAC from February 11, 1982 to June 17, 1983 and fromMarch 29, 1984 to September 14, 1984. Russo provided the workers' compensation coverage. Thereafter, ownership changed from AMFAC to Oregon Garden Products and on November 14, 1984, SAIF assumed coverage. Claimant worked for Oregon Garden Products from December 14, 1984 to October 4, 1985. She then worked for Iwasaki Brothers Nurseries from October 21, 1985. Iwasaki was insured by SAFECO.

In March 1985 claimant began seeing Dr. Ellis, chiropractor, complaining of back pain. Claimant expressed that the pain had never ceased since her January 1983 injury. Her complaints included low back and neck pain, pain and numbness in the right arm and hand.

On April 3, 1985, Russo denied claimant's aggravation claim. Approximately June 19, 1985 claimant filed a claim with Oregon Garden Products, SAIF's insured. At that time, she provided her employer with an authorization for her absence signed by Dr. Ellis on June 18, 1985. On February 28, 1986, SAIF denied a "new injury" claim for its insured. On April 7, 1986, SAFECO denied the claim for its insured.

The Referee assessed a penalty against SAIF for improper claims processing. This took into consideration its failure to pay interim compensation pending acceptance or denial, as well as the untimely denial. The Referee assessed a 25 percent penalty beginning June 19, 1985, the date SAIF's insured had knowledge of the claim, through the date of the Referee's order. We agree with the 25 percent penalty but modify the period against which the award is assessed.

ORS 656.262(4) provides that the first installment of compensation shall be paid no later than the 14th day after the

employer has notice or knowledge of the claim. ORS 656.262(2) construed together with subsections (4) and (5) requires the employer to pay interim compensation payments until the employer denies the claim. Jones v. Emanuel Hospital, 280 Or 147, 151 (1977). Additionally, a claim must be accepted or denied within 60 days after the employer has knowledge of the claim. ORS 656.262 (6). Here, SAIF's insured had knowledge of the claim on June 19, 1985. However, SAIF failed to pay any interim compensation and failed to deny the claim until February 1986. Consequently, claimant is entitled to penalties and attorney fees. ORRS 656.262(10); Jones, supra; Spivey v. SAIF, 79 Or App 568, 572 (1986).

Not only did SAIF fail to promptly process the claim, it failed to timely disclose medical documents to the attorneys for claimant and the other insurers. One set of documents consists of records from the Virginia Garcia Clinic. SAIF argues that it withheld these records from the other insurers and claimant because the records were for impeachment purposes only. The other document, however, was not withheld for impeachment purposes. At the time of the hearing, SAIF presented an authorization for claimant's absence signed by Dr. Ellis June 19, 1985. Neither claimant, nor the other insurers had been provided a copy of this document. At the time of the hearing, OAR 438-07-015(2) provided as follows:

> "Documents pertaining to claims are obtained by mailing a copy of the Request for Hearing, or a written demand, to the insurer. Within fifteen (15) days of said mailing the insurer shall furnish the claimant, without cost, copies of all medical and vocational reports, records of compensation paid, and other documents pertaining to the claim(s) which are then or come to be in the possession of the insurer, except that evidence offered solely for impeachment need not be so disclosed. Failure to comply with this section may be considered unreasonable delay or refusal under ORS 656.262(10)"

An insurer is not required to disclose information which is solely impeachment material. Therefore, SAIF acted properly in withholding the medical clinic records. However, SAIF as not entitled to withhold from disclosure the doctor's authorization for absence from work. Accordingly, an award of penalties and attorney fees is appropriate. See Clay B. Sheppard, 39 Van Natta 125 (1987).

Although technically entitled to a penalty for failure to comply with the administrative rule, the Referee is without legal authority to assess penalties totalling more than 25 percent of the compensation then due. Rob Cohen, 39 Van Natta 649, 652 (1987). Inasmuch as the Referee assessed a 25 percent penalty against the compensation then due as a penalty for improper claims processing, claimant is not entitled to an additional penalty for this issue. However, there is authority for an attorney fee for each unreasonable claims processing violation regardless of whether any penalty may be assessed. Id. Therefore, we award a $250 insurer-paid attorney fee for SAIF's failure to disclose the authorization for absence.

Finally, we find that this is a case of ordinary difficulty and usual probability of success for claimant. Accordingly, a reasonable attorney fee is awarded. Accordingly, we modify the Referee's order to award a 25 percent penalty against the time compensation then due between June 19, 1985, the date SAIF's insured had knowledge of the claim, and ending February 28, 1986, the date of the insurer's denial.

ORDER

The Referee's order dated December 24, 1986 is affirmed in part, modified in part, and reversed in part. That portion of the order that declined to award attorney fees for the SAIF Corporation's failure to timely disclose medical documents is reversed. Claimant's attorney is awarded $250, to be paid by SAIF. The period upon which the penalty is to be assessed for improper claims processing is modified. SAIF is assessed a penalty equal to 25 percent of the compensation due between June 19, 1985 and February 28, 1986. Claimant's attorney is awarded $600 for services on Board review concerning the compensability issue, to be paid by the SAIF Corporation. The remainder of the order is affirmed.

GRACE RANDALL, Claimant
Welch, et al., Claimant's Attorneys
SAIF Corp Legal, Defense Attorney

Own Motion 87-0762M
February 16, 1988
Own Motion Order

Claimant has requested that the Board exercise its own motion authority and grant her compensation for permanent total disability. Claimant's aggravation rights have expired.

Under the new law, which became effective January 1, 1988, permanent disability benefits can no longer be awarded after the aggravation period has expired. ORS 656.278(1)(a) and OAR 438-12-052(2). The request for permanent total disability must be denied.

IT IS SO ORDERED.

WARREN L. SPANGLER, Claimant
Vick & Gutzler, Claimant's Attorneys
SAIF Corp Legal, Defense Attorney

Own Motion 87-0535M
February 16, 1988
Own Motion Order

Claimant has requested that the Board exercise its own motion authority and reopen his claim for an alleged worsening of his December 31, 1981 industrial injury. Claimant's aggravation rights have expired. The Board postponed action on claimant's request pending resolution of WCB Case No. 87-14506. That matter has now been resolved with the Referee directing SAIF to accept responsibility for the recommended surgery. SAIF asks the Board to deny claimant's request for further benefits based on the fact that he collects disability benefits from the state of California.

Pursuant to ORS 656.278(1)(a) and OAR 438-12-052(2), along with the criteria in Cutright v. Weyerhaeuser Company, 299 Or 290 (1985), claimant is entitled to compensation for temporary total disability during the period of recuperation from surgery. We do not feel that receipt of disability benefits from the state of California under the arrangement described by claimant should preclude him from collecting workers' compensation benefits. Claimant's claim is hereby reopened with temporary total disability compensation to commence the date of surgery and to

continue until claimant returns to his regular work at his regular wage or is medically stationary, whichever is earlier. Reimbursement from the Reopened Claims Reserve is authorized to the extent allowed under ORS 656.625 and OAR 436, Division 45. When appropriate, the claim shall be closed by the insurer pursuant to OAR 438-12-055. Claimant's attorney is awarded 25% of the additional compensation granted by this order, not to exceed $650 as a reasonable attorney's fee.

IT IS SO ORDERED.

KAREN K. VANSANTEN, Claimant
Vick & Gutzler, Claimant's Attorneys
Brian Pocock, Defense Attorney

WCB 87-08817
February 16, 1988
Order Dismissing Request for Board Review

Claimant and her treating out-of-state chiropractor, Dr. Westerman, have separately requested Board review of Referee Quillinan's order that upheld the insurer's denial of claimant's medical services claim for her current neck condition. We have reviewed the requests to determine whether we have jurisdiction to consider the matter.

The Referee's order issued December 29, 1987. Dr. Westerman mailed a request for Board review on January 18, 1988. The request was received by the Board on January 20, 1988. Claimant mailed her request for review on January 28, 1988. The Board received the request on February 1, 1988. Neither request contained an acknowledgment of service or a certificate of personal service by mail upon the employer or its insurer.

A Referee's order is final unless, within 30 days after the date on which a copy of the order is mailed to the parties, one of the parties requests Board review under ORS 656.295. ORS 656.289(3). "Party" means a claimant for compensation, the employer of the injured worker at the time of injury and the insurer, if any, of such employer. ORS 656.005(19).

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

Inasmuch as Dr. Westerman is not a "party," he cannot validly request Board review. See ORS 656.005(19); 656.289(3). Furthermore, the record fails to establish that notice of either Dr. Westerman's or claimant's request was provided to the parties within the statutorily required 30-day period. See ORS 656.289(3); 656.295(2). 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 requested review without benefit of legal representation. We further realize that an unrepresented party is not expected to be familiar with administrative and procedural requirements of the Workers' Compensation Law. Yet, we are not free to relax a jurisdictional

requirement, particularly in view of Argonaut Insurance Co. v. King, supra. See Alfred F. Puglisi, 39 Van Natta 310 (1987); Julio P. Lopez, 38 Van Natta 862 (1986).

Accordingly, the request for Board review is dismissed.

IT IS SO ORDERED.

CLYDE BEAVERS, Claimant
Pozzi, et al., Claimant's Attorneys
Roberts, et al., Defense Attorneys
Schwabe, et al., Defense Attorneys
Thomas Johnson (SAIF), Defense Attorney

Own Motion 87-0012M, 87-0013M & 87-0014M
February 18, 1988
Own Motion Order

Claimant has requested that the Board exercise its own motion authority and grant him an award for permanent total disability. Claimant's aggravation rights have expired. The Board referred the request to the Hearings Division for consolidation with WCB Case Nos. 86-04575 and 87-00389. The Referee has recently ruled that SAIF Corporation and Liberty Northwest Insurance Corporation are not responsible for claimant's worsened condition since June 1980. He has placed responsibility for claimant's condition with Meier & Frank/May Company and recommends that the Board grant claimant an award for permanent disability. The Referee's order was not appealed and is now final by operation of law.

Under the new law, which became effective January 1, 1988, permanent disability benefits can no longer be awarded after the aggravation period has expired. ORS 656.278(1)(a) and OAR 438-12-052(2). The request for own motion relief must be denied.

IT IS SO ORDERED.

JACK BURTON, Claimant
Malagon & Moore, Claimant's Attorneys
SAIF Corp Legal, Defense Attorney

Own Motion 87-0674M
February 18, 1988
Second Own Motion Order on Reconsideration

The Board issued an Own Motion Order on December 21, 1987 whereby the request for reopening was denied on two grounds: (1) the September 30, 1987 stipulation rendered moot any request for reopening under ORS 656.278, and (2) claimant was out of the work force. Claimant asked the Board to reconsider its order and on January 21, 1987 a second order issued which again denied the relief sought.

Claimant has again requested reconsideration, providing additional information regarding his alleged retirement. We are persuaded that claimant was gainfully employed up to June 1987 when his treating doctor took him off work. After several months of lost time from work due to the compensable condition, claimant was forced to seek some type of financial support. He began receiving Social Security benefits in November 1987 in the amount of $271.

The September 30, 1987 stipulation remains an obstacle to the reopening of this claim. The stipulation clearly states that it resolves claimant's claim for permanent total disability and "any aggravation claim he may presently have." It could be argued that claimant did not have an aggravation claim, nor would he have one, as his claim is solely under the Board's authority in

ORS 656.278. It could also be argued that authorization for the surgery and the actual surgery itself came after the issuance of the stipulation. Under the new law, which became effective January 1, 1988, temporary total disability benefits may be allowed only when the injured worker is hospitalized or undergoes surgery. Since any possible time loss in this case came after the issuance of the stipulation, we conclude claimant's claim can be reopened under our own motion authority.

Claimant's claim is hereby reopened with temporary total disability compensation to commence November 20, 1987 and to continue until claimant returns to his regular work at his regular wage or is medically stationary, whichever is earlier. Reimbursement from the Reopened Claims Reserve is authorized to the extent allowed under ORS 656.625 and OAR 436, Division 45. When appropriate, the claim shall be closed by the insurer pursuant to OAR 438-12-055. Claimant's attorney is awarded 25% of the additional compensation granted by this order, not to exceed $550 as a reasonable attorney's fee.

IT IS SO ORDERED.

DORIS R. STAACK, Claimant
Vick & Associates, Claimant's Attorneys
SAIF Corp Legal, Defense Attorney
Nelson, et al., Defense Attorneys
Williams & Zografos, Defense Attorneys
Acker, et al., Defense Attorneys

WCB 85-03614, 85-01512 & 85-01511
February 18, 1988
Order on Remand

This matter is before the Board on remand from the Court of Appeals. Staack v. Santiam Memorial Hospital, 86 Or App 290 (1987). The court has concluded that claimant's need for right ankle surgery in 1984 was related to her 1976 compensable knee disease and that the treatment was reasonable and necessary. Consequently, we have been instructed to award benefits for medical services under claimant's 1976 claim with Liberty Northwest Insurance Corporation (Liberty), the insurer for Santiam Memorial Hospital.

Accordingly, Liberty's January 10, 1985 denial is set aside insofar as it purported to deny responsibility for claimant's medical services claim for her current right ankle condition. The claim is remanded to Liberty for processing according to law.

IT IS SO ORDERED.

PATRICIA M. VanBLOKLAND, Claimant
Peter O. Hansen, Claimant's Attorney
SAIF Corp Legal, Defense Attorney

WCB 83-06632
February 18, 1988
Order on Remand

This matter is before the Board on remand from the Court of Appeals. Van Blokland v. Oregon Health Sciences University, 87 Or App 694 (1987). The court has concluded that claimant's Risk Factor Obesity Program is a compensable medical treatment and that the claim was prematurely closed. Consequently, we have been instructed to set aside the denial of payment for claimant's weight loss program and to reopen the claim.

Accordingly, the SAIF Corporation's "de facto" denial of

payment for the Risk Factor Obesity Program is set aside. Furthermore, the October 15, 1985 Determination Order is set aside as premature and the claim is remanded to SAIF for processing according to law.

IT IS SO ORDERED.

JOSEPH WILSON, Claimant
Michael B. Dye, Claimant's Attorney
E. Jay Perry, Defense Attorney
Carl Davis, Assistant Attorney General

WCB 87-08970
February 18, 1988
Order Dismissing Request for Board Review (Remanding)

Claimant has requested Board review of the Referee's January 6, 1988 "Order on Motion to Dismiss." We have reviewed the request to determine whether the Referee's order is a final order which is subject to review. Zeno T. Idzerda, 38 Van Natta 428 (1986).

The Referee found that Eagle Pacific Insurance Company was not a workers' compensation insurer for claimant's alleged employer, Robert Jack Trucking. Consequently, the Referee dismissed Eagle Pacific as a party to a forthcoming proceeding concerning claimant's contentions that his alleged employer, whether complying or noncomplying, had not processed his claim according to law. The parties were also advised that the case would be held in abeyance pending the scheduling of further proceedings. The Referee's order did not contain a statement explaining the parties' rights of appeal pursuant to ORS 656.289(3).

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

Here, the Referee's order neither finally disposed of, nor allowed, the claim. Moreover, the order did not fix the amount of claimant's compensation. Rather, the order was "interim" in nature. In essence, it notified Eagle Pacific that its appearance at a future hearing concerning claimant's contentions was not required and that formal approval of its motion to dismiss would eventually be incorporated into a final, appealable order. A preliminary order such as this is in keeping with the Board's interest in avoiding piecemeal review of multiple issues arising in a single case. See Harris E. Jackson, 35 Van Natta 1674, 1676 (1983).

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

Accordingly, the request for Board review is dismissed and this matter is remanded to the Hearings Division for further proceedings.

IT IS SO ORDERED.

VIRGIL BROGAN, Claimant
Peter O. Hansen, Claimant's Attorney
Jill Riechers (SAIF), Defense Attorney

WCB 86-12575
February 19, 1987
Order Denying Motion to Strike Reply Brief

The SAIF Corporation has moved the Board for an order striking claimant's reply brief. The motion is denied.

Claimant's second request for an extension of time within which to file his appellant's brief was denied. Thereafter, SAIF submitted a document which it specifically identified as a "Respondent's Brief." Relying on the Referee's reasoning, SAIF briefly requested that the order be affirmed. Claimant timely filed a reply brief, discussing the Referee's order and contending that it should be reversed.

SAIF objects to the reply brief, asserting that to allow the brief "in lieu" of an appellant's brief circumvents the Board's briefing schedule. We agree with SAIF's argument insofar as it applies to situations where neither an appellant's nor a respondent's brief have been filed. Under such circumstances, there is nothing upon which to reply. See Alvin L. Woodruff, 39 Van Natta 1161 (1987). We further agree that untimely filed appellant's briefs that are resubmitted in reply to cross-appellant's briefs should not be considered. See Deryl E. Fisher, 38 Van Natta 982 (1986).

However, SAIF chose to file an expressly entitled "Respondent's Brief." Consequently, claimant's brief was not "in lieu" of an appellant's brief. Rather, the brief was in reply to SAIF's "Respondent's Brief." Had SAIF wished to merely rely upon the Referee's reasoning, it could have done so in a letter, specifically waiving its opportunity to submit a brief. Yet, because SAIF chose to file a "Respondent's Brief," claimant was entitled to file a reply.

Inasmuch as the reply brief was not a resubmitted appellant's brief and was timely filed, it will be considered on Board review.

Accordingly, the motion to strike claimant's reply brief is denied. This matter will now be docketed for review.

IT IS SO ORDERED.

ROBERT G. EBBERT, Claimant
Pozzi, et al., Claimant's Attorneys
Schwabe, et al., Defense Attorneys

WCB 87-04189
February 19, 1988
Order of Dismissal

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

The Referee's order issued December 30, 1987. On February 1, 1988, claimant mailed a copy of a request for Board review of the Referee's order to the insurer's counsel, who received the document the following day. The request for Board review was dated January 27, 1988. The Board has no record of receiving a 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).

Here, claimant's request for Board review was dated within 30 days of the Referee's order. However, the record fails to establish that the request was ever mailed to or received by the Board. Furthermore, the insurer was neither timely mailed a copy of the request nor did it receive actual knowledge of the request within the statutory 30-day period. Under these circumstances, we lack jurisdiction to review the Referee's order, which has become final by operation of law. See ORS 656.289(3); ORS 656.295(5); Argonaut Insurance Co. v. King, supra.

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

Accordingly, the request for Board review is dismissed.

IT IS SO ORDERED.

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

WCB TP-87031
February 19, 1988
Interim Order of Partial Distributio

Claimant has petitioned the Board to resolve a dispute concerning a proposed settlement of a third party action. Specifically, he asks that the Board approve a proposed third party settlement. See ORS 656.587. In addition, claimant requests that we order the distribution of the settlement's proceeds.

In March 1987 claimant sustained a compensable back injury when the van he was operating was struck from behind by another motor vehicle. His condition was diagnosed as a strain/sprain of the cervical dorsal spine "with associated myofascitis and cephalgia complicated by a preexisting chronic cervical strain." With some restrictions, he has been able to continue his work duties as a driver and delivery man for a water company.

In July 1987 Dr. Underhill, claimant's treating physician, advised claimant's attorney that the compensable condition was medically stationary, with some degree of residuals. Underhill concluded that it was "too early to tell how much continuing care will be required."

To date, the SAIF Corporation, as paying agency, has expended $861 in medical benefits. The claim is presently

awaiting closure, pending SAIF's receipt of a closing examination from claimant's treating physician.

Claimant initiated a cause of action against the driver of the vehicle. Prior to trial, he and the third party's insurer have agreed to settle the matter for $6,358. In its response to claimant's petition, SAIF has approved the settlement. Since no dispute concerning the compromise exists, Board approval is unnecessary. See ORS 656.587.

We turn to the "distribution of proceeds" issue. The proceeds of any damages from a third party recovery shall be distributed in accordance with ORS 656.593(1). That is, following the distribution of costs, attorney fees, and the worker's 1/3 statutory share, the paying agency shall be paid and retain the balance of the recovery.

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

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

The parties agree that claimant's attorney fees, litigation costs, and his 1/3 share should be distributed pursuant to ORS 656.593(1). However, claimant contends that SAIF's lien should be limited to its current claim costs because it has "unreasonably delayed" closing the claim. Claimant asserts that SAIF's dilatory conduct has prevented them from promptly resolving the extent of permanent disability issue.

Claimant's contentions primarily focus on the processing of his workers' compensation claim. Since these contentions are "question[s] concerning a claim," the appropriate forum to consider them would be the Hearings Division pursuant to ORS 656.283. Pursuant to claimant's petition for relief, the Board presently retains jurisdiction over this matter to resolve a conflict concerning "what may be a just and proper distribution" of proceeds from a third party settlement. ORS 656.593(3). In this capacity, we are authorized to determine the amount of a paying agency's "just and proper" share of the proceeds. id.

Because the claim has not been closed, it is unclear what, if any, permanent disability claimant has sustained as a result of his compensable injury. Since there has not been a final order determining the extent of claimant's disability arising out of his compensable injury, we deem it appropriate to defer ruling on the question of SAIF's entitlement to a lien for anticipated future expenditures. See Robert B. Williams, 37 Van Natta 711 (1985); George Bedsaul, 35 Van Natta 695 (1983); John J. O'Halloran, 34 Van Natta 1504 (1982).

Accordingly, claimant's attorney is ordered to distribute the proceeds of the third party settlement in accordance with ORS 656.593(1)(a), and (b). Thereafter, claimant's attorney is ordered to pay to SAIF, as reimbursement for its actual claim costs incurred to date, the sum of $861. The remaining balance of the proceeds shall be held by claimant's attorney in trust pending a final determination concerning the extent of claimant's permanent disability. Upon final resolution of the disability issue, the parties shall notify the Board of their respective positions. Should a dispute continue to exist, the Board will order distribution of the remaining balance.

IT IS SO ORDERED.

LEROY FRANK, Claimant
Vick & Gutzler, Claimant's Attorneys
SAIF Corp Legal, Defense Attorney

Own Motion 88-0059M
February 16, 1988
Own Motion Determination

SAIF Corporation has submitted to the Board claimant's claim for an alleged worsening of his July 23, 1981 industrial injury. Claimant's claim was originally classified as a non-disabling claim in 1981. He now seeks an award for permanent partial disability.

The Board concludes that this request is in its jurisdiction. ORS 656.273(4)(b) and Smith v. Ridgepine, Inc., 88 OR App 147 (1987). However, we are unable to consider the request for an award of permanent disability. Pursuant to ORS 656.278(1)(a) and OAR 438-12-052(2) permanent disability benefits can no longer be awarded after the aggravation period has expired. The request for own motion relief is hereby denied.

IT IS SO ORDERED.

ESTHER C. BEASLEY, Claimant
Coons & Cole, Claimant's Attorneys
Alice M. Bartelt, Defense Attorney

WCB 85-06921
February 22, 1988
Order on Review

Reviewed by Board Members Johnson and Ferris.

Claimant requests review of those portions of Referee Knapp's order that: (1) declined to grant permanent total disability; (2) awarded a total of 40 percent (128 degrees) unscheduled permanent partial disability for a low back injury, in lieu of a Determination Order award of 25 percent (80 degrees); (3) declined to assess attorney fees for the insurer's failure to timely comply with OAR 436-10-070; and (4) awarded a reasonable insurer-paid attorney fee of $500 for claimant's attorney's services in setting aside the insurer's denial of claimant's claims for mileage reimbursement and medical services. The issues on review are permanent total disability, extent of permanent disability, claims processing and attorney fees.

We reverse that portion of the order denying attorney fees for the insurer's failure to comply with an administrative rule.

In August 1983 claimant compensably injured her low back. Acute lumbosacral myofascitis was diagnosed. X-rays also revealed severe disc space narrowing at L5-S1. An April 6, 1984

Determination Order awarded 25 percent unscheduled permanent disability for claimant's low back condition.

In May 1985 claimant's condition worsened and on July 11, 1985, Dr. Berkeley, her treating neurological surgeon, requested authorization for decompression surgery. The insurer asked Dr. Schmidt, neurological surgeon, to perform an independent medical examination. On August 2, 1985, Dr. Schmidt reported that claimant had a low to moderate probability of improving her symptoms after surgery.

On September 24, 1985, claimant's attorney demanded that the insurer "take a position immediately regarding the requested authorization for surgery." The attorney further stated that:

> "[I]n the absence of a response by [the insurer] within seven (7) days of date of this letter, I will request a hearing seeking the imposition of penalties and attorney fees on account of the failure to comply with the pertinent administrative rules."

On September 27, 1985, the insurer authorized the surgery.

Inasmuch as claimant was receiving compensation during this period, the Referee concluded that there were no amounts then due upon which to assess a penalty for an unreasonable delay in responding to the requested surgery. See Wilma K. Anglin, 39 Van Natta 73, 73 (1987)(costs of medical services are not amounts "then due" within the meaning of ORS 656.262(10) until the services have actually been performed). Furthermore, because the insurer had complied with the attorney's September 24, 1985 letter, the Referee reasoned that the issues of penalties and attorney fees had been waived. We hold that an attorney fee is assessable.

When major elective orthopedic or neurological surgery is recommended, an insurer may request a second opinion as to the need of the surgery. OAR 436-10-070(2). The insurer has 72 hours after receipt of the consulting doctor's report, to notify the treating surgeon authorizing or denying surgery. OAR 436-10-070(3)(a).

If an 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). ORS 656.382(1) provides that if an insurer unreasonably resists the payment of compensation, the insurer shall pay to the claimant or the attorney of the claimant a reasonable attorney fee.

Here, before the insurer received claimant's attorney's demand letter, it had already failed to timely deny or authorize surgery. Under these circumstances, we conclude that its nonaction constituted undue delay in processing a claim and misconduct. ORS 656.262(10) and 656.382 apply in this situation. Furthermore, we do not consider claimant's attorney's letter to be a waiver of her rights under the Workers' Compensation Act. The objectives of the Workers' Compensation Laws are to provide prompt and complete medical treatment for injured workers, to provide a fair and just administrative system for delivery of medical benefits, and to restore injured workers physically to a

self-sufficient status in an expeditious manner. ORS 656.012(a)-(c). If the letter was interpreted to be a waiver, it would be in contradiction of the objectives enunciated in the aforementioned statutes and rule.

Considering that the insurer has failed to provide any justification for its delay in authorizing the requested medical services, we find its conduct unreasonable. Accordingly, claimant is awarded an insurer-paid attorney fee in the amount of $400. This fee is awarded pursuant to the standards established in Barbara Wheeler, 37 Van Natta 122, 123 (1987).

We affirm the remainder of the Referee's order.

ORDER

The Referee's order dated April 7, 1987 is affirmed in part and reversed in part. Claimant's attorney is awarded a $400 reasonable attorney fee, to be paid by the insurer. The remainder of the Referee's order is affirmed.

ANTHONY D. ELLENA, Claimant
Magar E. Magar, Claimant's Attorneys
Mitchell, et al., Defense Attorneys

WCB 85-00709
February 22, 1988
Order on Review

Reviewed by Board Members Crider and Johnson.

Claimant requests review of that portion of Referee Peterson's order that declined to award scheduled permanent disability for loss of use or function of the right wrist, in addition to the 5 percent (7.5 degrees) previously awarded by a Determination Order. On review, the claimant contends that he is entitled to an award of unscheduled permanent disability.

The insurer has moved the Board for an order dismissing claimant's request for review on the ground that claimant did not file a brief within the time allowed by the briefing schedule. Briefing is not jurisdictional. ORS 656.295(1); OAR 438-11-020(1). The motion is denied.

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

ORDER

The Referee's order dated February 25, 1987 is affirmed.

DAVID (last name n/a), Claimant
Quintin B. Estell, Claimant's Attorney
Davis, Bostwick, et al., Defense Attorneys

WCB 86-09206
February 25, 1988
Order on Review

Reviewed by Board Members Ferris and Johnson.

The insurer requests review of that portion of Referee Peterson's order that awarded claimant temporary disability compensation in addition to that awarded by a Determination Order. Claimant cross-requests review of that portion of the Referee's order that declined to assess penalties and attorney fees for the insurer's alleged unreasonable failure to pay the additional temporary disability benefits prior to the Referee's order. The issues are temporary disability, penalties and attorney fees.

The Board affirms the order of the Referee.

Claimant failed to timely file his brief on review. Nevertheless, he has prevailed over an insurer-initiated request for review. We have previously held that ORS 656.382(2) mandates an insurer-paid attorney fee under such circumstances. Charles D. Barney, 39 Van Natta 646 (1987). Accordingly, we award an attorney fee commensurate with the efforts expended and the results obtained on review. See OAR 438-47-010.

ORDER

The Referee's order dated May 1, 1987 is affirmed. Claimant's attorney is awarded $100 for services on Board review concerning the temporary disability compensation issue, to be paid by the insurer.

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

WCB 86-11759
February 25, 1988
Order on Review

Reviewed by Board Members Crider and Johnson.

The self-insured employer requests review of Referee Mulder's order that set aside its partial denial of claimant's injury claim for a chronic thoracic strain, left shoulder strain and cervical strain. The issue is compensability.

The Board affirms the order of the Referee.

Claimant failed to timely file her brief on review. Nevertheless, she has prevailed over an insurer-initiated request for review. We have previously held that ORS 656.382(2) mandates an insurer-paid attorney fee under such circumstances. Charles D. Barney, 39 Van Natta 646 (1987). Accordingly, we award an attorney fee commensurate with the efforts expended and the results obtained on review. See OAR 438-15-070.

ORDER

The Referee's order dated June 3, 1987 is affirmed. Claimant's attorney is awarded $150 for services on Board review concerning the compensability issue, to be paid by the self-insured employer.

JOSE L. ARCIGA, Claimant
Francesconi & Cash, Claimant's Attorneys
Eckley & Associates, Defense Attorneys
Thomas H. Johnson (SAIF), Defense Attorney
Carl M. Davis, Assistant Attorney General

WCB 86-13690
February 25, 1988
Order on Review

Reviewed by Board Members Johnson and Crider.

The alleged noncomplying employer, McKay Creek Farm, requests review of Referee Menashe's order that: (1) set aside the SAIF Corporation's denial, on McKay's behalf, of claimant's left leg injury claim; and (2) awarded claimant's attorney an attorney fee for services at hearing. On review, the issues are compensability and attorney fees. The parties have filed no briefs.

The Board affirms the order of the Referee.

Although the parties filed no briefs, claimant's attorney shall be awarded a nominal attorney fee for technically prevailing against McKay's request for review. See ORS 656.382(2); Rita Mitchell, 39 Van natta 436 (1987).

ORDER

The Referee's order dated February 18, 1987, is affirmed. Claimant's attorney is awarded $100 for services on Board review, to be paid by the SAIF Corporation on behalf of McKay Creek Farm.

MICHAEL D. BRUNER, Claimant

Own Motion 88-0065M
February 25, 1988
Own Motion Order

The insurer has submitted to the Board claimant's claim for an alleged worsening of his March 10, 1980 industrial injury. Claimant's aggravation rights have expired. The insurer has authorized the recommended surgery and does not object to claim reopening under ORS 656.278.

Claimant's claim is currently in a closed status and, as such, must be considered by the Board under the new own motion law. Under this law, which became effective January 1, 1988, temporary total disability benefits may be allowed only when the injured worker is hospitalized or undergoes surgery. We conclude claimant's claim should be reopened with temporary total disability compensation to commence the date of the surgery and to continue until claimant returns to his regular work at his regular wage or is medically stationary, whichever is earlier. Reimbursement from the Reopened Claims Reserve is authorized to the extent allowed under ORS 656.625 and OAR 436, Division 45. When appropriate, the claim shall be closed by the insurer pursuant to OAR 438-12-055.

IT IS SO ORDERED.

JERRY V. BUCKLE, Claimant
W.D. Bates, Jr., Claimant's Attorneys
Brian L. Pocock, Defense Attorney

WCB 86-00040
February 25, 1988
Interim Order (Remanding)

Reviewed by Board Members Crider and Johnson.

The self-insured employer requests review of those portions of Referee Michael Johnson's order that: (1) set aside its denial of claimant's upper torso and neck injury claim; and (2) awarded a reasonable attorney fee of $1,300. In his brief, claimant contends that the Referee erred in declining to assess a penalty and attorney fee for an unreasonable denial.

We note that the Referee admitted into evidence Exhibits 8A and 8B. A cover letter from the employer's attorney identifies these exhibits as a medical report and chart notes, dated November 11, 1985, from claimant's treating physician, Dr. Baker. However, the record on review does not contain either exhibit.

Pursuant to ORS 656.295(5), we may remand to the Referee for further evidence taking, correction or other necessary action when we determine that a case has been improperly, incompletely,

or otherwise insufficiently developed. We conclude that the omission of Exhibits 8A and 8B constitutes an improper, incomplete, or otherwise insufficient development of this case.

Accordingly, we remand to the Referee to reconsider this matter in light of our discovery. Should the Referee conclude that a hearing is necessary to identify the aforementioned exhibits and include them in the record, he is directed to initiate the appropriate proceedings. The Referee is further directed to issue an interim order on remand indicating the effect, if any, the reports' inclusion into the record has upon his original order. We retain jurisdiction over this case, pending receipt of the Referee's interim order.

ORDER

This case is remanded to the Referee for further action consistent with this order.

TERRY J. ERICKSON, Claimant
Royce, et al., Claimant's Attorneys
Meyers & Terrall, Defense Attorneys

WCB 86-13441
February 25, 1988
Order of Dismissal

The self-insured employer requested Board review of Referee Lipton's October 21, 1987 order. The employer has now withdrawn its request for review.

Accordingly, the request for review now pending before the Board is dismissed and the order of the Referee is final by operation of law.

Claimant requests an insurer-paid attorney fee for "prevailing" against the employer's request for review. The request is denied. Where an insurer's or employer's request for Board review is dismissed prior to a decision on the merits, claimant is not entitled to an attorney fee. Agripac, Inc. v. Kitchel, 73 Or App 132 (1985); Leland O. Bales, 38 Van Natta 25 (1986); Rodney C. Strauss, 37 Van Natta 1212, 1214 (1985).

Finally, after reviewing the statement of services submitted by the employer's attorney and considering the factors set forth in OAR 438-15-010(6), we approve a client-paid fee not to exceed $683.50. We do not consider the attorney's estimate of an additional two hours to evaluate the possibility of appealing the Board's order to be reasonable, particularly when it is the employer that has withdrawn its request for Board review.

IT IS SO ORDERED.

RICHARD FISCHER, Claimant
Cash Perrine, Claimant's Attorney
Gary Wallmark (SAIF), Defense Attorney

WCB 86-04217
February 25, 1988
Order on Review

Reviewed by Board Members Crider and Johnson.

Claimant requests review of Referee Nichols' order that declined to award claimant permanent total disability, but increased her unscheduled permanent disability award for a low back condition from 50 percent (160 degrees), as awarded by Determination Order, to 90 percent (288 degrees). In his brief, claimant requests that the Board remand the case for further

psychiatric evaluation to determine if his motivational problems are beyond his control. On review, the issues are remand and extent of unscheduled permanent disability, including permanent total disability.

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 psychiatric evaluation requested by claimant was obtainable with due diligence at the time of hearing. Furthermore, we conclude that the record has not been improperly, incompletely or otherwise insufficiently developed. 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 March 2, 1987 is affirmed.

HOWARD GAROUTTE, Claimant
Patrick K. Mackin, Claimant's Attorney
SAIF Corp Legal, Defense Attorney

Own Motion 86-0563M
February 25, 1988
Own Motion Order

Claimant has requested that the Board exercise its own motion authority and reopen his claim for an alleged worsening of his February 1976 industrial injury. Claimant's aggravation rights have expired. The Board referred the request for own motion relief to the Hearings Division for consolidation with WCB Case No. 85-13438. That matter was recently resolved by Opinion and Order. Referee St. Martin also recommended to the Board that it reopen claimant's 1976 claim for an increased award of permanent disability.

Claimant's original request for own motion relief specifically seeks compensation for temporary total disability and permanent partial disability. SAIF has indicated its opposition to the relief claimant seeks. Under the new law, which became effective January 1, 1988, temporary total disability may be allowed only when the injured worker is hospitalized or undergoes surgery. Permanent disability benefits can no longer be awarded after the aggravation period has expired. ORS 656.278(1)(a) and OAR 438-12-052(2). Under the facts of this case, the Board must deny all relief requested by claimant.

IT IS SO ORDERED.

FRANKLIN A. HARRIS, Claimant
S. David Eves, Claimant's Attorney
E. Jay Perry, Defense Attorney
Jeff Gerner (SAIF), Defense Attorney

WCB 86-17125
February 25, 1988
Order on Review

Reviewed by Board Members Crider and Johnson.

The alleged noncomplying employer, Beta Computers, requests review of that portion of Referee Emerson's order that set aside the SAIF Corporation's denial, on Beta's behalf, of claimant's left hip injury claim. On review, the issue is compensability. The parties have filed no briefs.

The Board affirms the order of the Referee.

Although the parties filed no briefs, claimant's attorney shall be awarded a nominal attorney fee for technically prevailing against Beta's request for review. See ORS 656.382(2); Rita Mitchell, 39 Van Natta 436 (1987).

ORDER

The Referee's order dated March 3, 1987, is affirmed. Claimant's attorney is awarded $100 for services on Board review, to be paid by the SAIF Corporation on behalf of Beta Computers.

RICK W. HOWARD, Claimant
Peter O. Hansen, Claimant's Attorney
Jill Reichers (SAIF), Defense Attorney

WCB 86-13575
February 25, 1988
Order on Review

Reviewed by Board Members Johnson and Crider.

The SAIF Corporation requests review of that portion of Referee Fink's order that set aside its denial of claimant's aggravation claim. On review, the issue is aggravation.

We affirm the Referee with the following comment.

Claimant compensably injured his low back and left foot while working as a carpenter in April 1981. Following his injury, claimant experienced low back pain, radiating into the left buttock and leg, as well as left foot weakness and numbness.

The diagnosis was sciatica, and a possible herniated disc, superimposed on a preexisting spondylitic defect. Claimant was treated conservatively by Dr. Kaesche, orthopedist. Dr. Kaesche permanently restricted claimant from returning to his former work or any type of heavy labor.

Dr. Davis, orthopedic surgeon, performed an independent medical examination in September 1981. He noted significant restrictions in spinal ranges of motion, but reported that claimant's left foot had healed without residuals.

A Determination Order issued October 23, 1981, awarding claimant 25 percent unscheduled permanent partial disability for his low back injury. On the same day, SAIF received a copy of Dr. Kaesche's chart notes for October 19, 1981, reporting a flare-up of claimant's left foot symptoms. Subsequent chart notes indicate that these symptoms had subsided by the following month.

Claimant requested a hearing concerning the Determination Order. In August 1983, a prior Referee increased claimant's permanent disability award to 45 percent. That Referee stated that claimant continued to suffer from persistent low back pain, mostly on the left and extending into the left buttock, associated with any motion, jerking, twisting, turning or bending. The Referee also discussed Dr. Davis' September 1981 report, stating that claimant's left foot had healed without residuals.

The prior Referee further noted claimant's testimony that: there were days when he "can't seemingly do anything;" this occurs about twice a month; claimant develops pain in the low back and buttocks while working; his left leg feels like it's going to sleep; and he takes a break every hour in order to continue working.

Claimant continued to report waxing and waning of back and left leg and foot symptoms. In February 1985, Dr. Kaesche reported a recurrence of left leg and foot symptoms, including positive straight leg raising, and decreased sensation. Thereafter, the claim was reopened. On March 5, 1985, Dr. Kaesche reported improvement in claimant's condition and released him back to work. The claim was closed by a Determination Order, issued June 11, 1985, which awarded no additional permanent disability.

Claimant requested a hearing from this Determination Order. In December 1985, the parties entered into a stipulation which awarded claimant an additional 15 percent unscheduled permanent partial disability, for a total award of 60 percent. This was the last award of compensation. At that time, claimant had been retrained in television work and was working full time in that field.

The record indicates that claimant did not again seek treatment until June 1986. Claimant credibly testified that he awoke on the morning of June 10, 1986, with pain so severe that it took him an hour to get out of bed. He stated that he had previously experienced that degree of pain on only one or two other occasions.

Claimant sought treatment from Dr. Kaesche, who also reported weakness, numbness, and loss of range of motion in claimant's left foot. Dr. Kaesche prescribed bed rest for two weeks. Following the two weeks of rest, claimant returned to work, and began a physical therapy program prescribed by Dr. Kaesche. On October 8, 1986, Dr. Kaesche stated that claimant might have reached the point where surgery was indicated.

Claimant filed an aggravation claim which SAIF received on July 10, 1986. SAIF began paying interim compensation on August 1, 1986. It formally denied the claim on September 16, 1986, contending that claimant's symptoms had not worsened since his last award of compensation.

The Referee found that claimant had established an aggravation. On review, SAIF contends that claimant's underlying condition has not worsened and that his current symptoms were contemplated by, and consistent with, his last award of compensation.

We affirm the Referee's ruling on the aggravation issue with the following comment. The Referee apparently found that Dr. Kaesche's verification of claimant's inability to work was sufficient to establish an aggravation. However, medical verification of inability to work, in and of itself, does not establish an aggravation. Rather, it merely establishes an aggravation claim which the insurer must accept or deny in a timely manner. ORS 656.273(3); Stevens v. Champion International, 44 Or App 587 (1980).

In order to establish a compensable aggravation, claimant must prove that his condition has worsened, since his last award of compensation, so that claimant is more disabled, meaning less able to work, either temporarily or permanently. ORS 656.273(1); Smith v. SAIF, 302 Or 396 (1986).

Furthermore, increased symptoms, in and of themselves, do not establish an aggravation unless they result in additional loss of earning capacity. Smith v. SAIF, 302 Or 396 (1986); Van Woesik v. Pacific Coca-Cola Co., 85 Or App 9 (1987). If the last award of compensation contemplated some waxing and waning of symptoms, claimant must show that his current symptoms resulted in greater inability to work than anticipated by the last award. See Gwynn v. SAIF, 304 Or 345 (1987).

After de novo review, we find that claimant's symptoms had worsened in June 1986 so that he was less able to work than at the time of his last arrangement of compensation. Accordingly, we affirm the Referee's order setting aside SAIF's denial of claimant's aggravation claim.

In reaching our decision, we note that claimant credibly testified that he had previously experienced the degree of pain he felt in June 1986 on only one or two occasions. In addition, these symptoms prompted his long-time treating physician to prescribe bed rest for two weeks, whereas claimant was successfully working full-time at the time of his last arrangement of compensation. Moreover, following the June 1986 incident, claimant suffered for the first time from foot symptoms related to the compensable injury, and his treating physician opined for the first time that claimant may have reached the point at which surgery was indicated.

We also note that there is no evidence in the record from which we might infer an intention, at the time of the last arrangement of compensation, to compensate claimant for anticipated waxing and waning of symptoms. See Gwynn v. SAIF, Id. The last arrangement of compensation was a December 12, 1985 stipulation. Nothing in the stipulation states that the parties anticipated a waxing and waning of symptoms. Moreover, there was no hearing following the June 1, 1984 and June 11, 1984 post-vocational training Determination Orders. As a result, there is no evidence from which it can be determined why the parties chose to increase claimant's permanent partial disability award beyond the amount awarded by the April 17, 1984 Opinion and Order.

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

ORDER

The Referee's order dated March 10, 1987 is affirmed. Claimant's attorney is awarded $400 for services on Board review concerning the issue of aggravation, to be paid by the SAIF Corporation.

DIANE L. JOHNSON, Claimant

Own Motion 86-0320M
February 25, 1988
Own Motion Order on Reconsideration

The Board issued an Own Motion Order on June 10, 1986 whereby claimant's request for own motion relief was denied as it was found claimant had removed herself from the work force and could not be paid temporary total disability compensation during her recuperation from surgery. Claimant asks that the Board reconsider its order based on submitted tax forms for the year 1984. The insurer has not responded to claimant's request.

Claimant has provided evidence that she was employed as a Shaklee salesperson in 1984. Her tax forms indicate that she had a gross income of $67.00 for the year 1984. We cannot conclude from this information that claimant was gainfully employed in 1984. Also, we find no evidence of work activity in 1985 or 1986. Dr. Berselli has indicated that claimant's condition worsened in October 1985 and surgery was subsequently done in June 1986. Claimant has failed to provide evidence that she was gainfully employed prior to her worsening and subsequent surgery. The request for own motion relief must be denied.

IT IS SO ORDERED.

The Beneficiaries of
ROCKNE LUCKMAN (Deceased), Claimant
Martin McKeown, Claimant's Attorney
Kate Donnelly (SAIF), Defense Attorney

WCB 85-12369 & 86-04809
February 25, 1988
Order on Review

Reviewed by Board Members Johnson and Crider.

The SAIF Corporation requests review of those portions of Referee Brown's order that: (1) set aside its denial of decedent's beneficiary's death benefits claim; and (2) awarded the beneficiary an attorney fee for prevailing against its "back-up" denial of decedent's prior eye injury claim. The issues are whether the decedent was a subject employe and attorney fees.

The Board affirms the Referee's order with the following comment concerning whether decedent was a subject employe.

Decedent, a corporate officer, was a director and 50 percent shareholder of SAIF's insured. In March 1984, SAIF's insured purchased workers' compensation coverage. When purchasing the coverage, SAIF's insured did not request personal election coverage for decedent. Shortly thereafter, SAIF informed its insured that it was not providing coverage for corporate officers who were directors and substantial shareholders in the corporation.

The office manager for SAIF's insured, Mr. Herman, regularly submitted payroll reporting forms to SAIF. The face of these reporting forms, provided by SAIF, do not indicate that wages for corporate officers are to be excluded in calculating

premiums. Claimant's wages were included in the calculation and reporting of premiums. Herman testified that he had assumed corporate officers and directors had coverage.

In April 1985, decedent sustained an on-the-job eye injury and filed an 801 claim form with SAIF. The form contains a space, which inquires: "Is the injured worker a corporate officer, partner, or sole proprietor?" In response, claimant checked the "yes" box. SAIF accepted the eye injury claim as a non-disabling injury. Medical bills were neither submitted nor paid.

In August 1985, decedent was killed while on-the-job. His beneficiary filed a death benefits claim. Asserting that decedent did not have personal election coverage, SAIF denied the claim.

The Referee applied ORS 656.128 and found that the April 1985 801 form was a written application for personal election coverage. We agree with the Referee's ultimate conclusion. However, we apply different reasoning.

ORS 656.027(7), et seq, provides that sole proprietors, certain partners, and corporate officers who are directors with a substantial ownership interest in the corporation, are not subject employes.

ORS 656.128 states, inter alia:

> "(1) Any person who is a sole proprietor, or a member of a partnership, may make written application to an insurer to become entitled as a subject worker to compensation benefits." (Emphasis added).

Here, claimant was neither a sole proprietor nor a member of a partnership. Rather, he was a corporate officer. Inasmuch as ORS 656.128 does not include corporate officers, it is not applicable to the instant case.

ORS 656.039, however, is applicable and provides, inter alia:

> "(4) Notwithstanding any other provision of this section, a person or employer not subject to this chapter who elects to become covered may apply to a guaranty contract insurer for coverage. An insurer other than the State Accident Insurance Fund Corporation may provide such coverage. However, the State Accident Insurance Fund Corporation shall accept any written notice filed and provide coverage as provided in this section if all subject workers of the employers will be insured with the State Accident Insurance Fund Corporation . . . ." (Emphasis added).

Here, decedent was a corporate officer, director, and 50 percent shareholder of SAIF's insured. Therefore, he was not a subject employe pursuant to ORS 656.027(9), unless he filed for

personal election coverage. In our view, the April 1985 801 claim form satisfies the "any written notice filed" requirement under ORS 656.039(4). See also SAIF v. D'Lyn, 74 Or App 64, 68 (1985). Moreover, at the time of decedent's death, all subject workers of SAIF's insured were covered by SAIF. Since claimant had filed for personal election coverage pursuant to ORS 656.039(4), SAIF was required to accept the application and provide workers' compensation coverage.

Accordingly, after our de novo review, we find that claimant was a subject employe at the time of his death.

Furthermore, we find that the coverage issue presents a question of ordinary difficulty with the usual probability of success for decedent's beneficiary on Board review. A reasonable attorney fee is therefore awarded.

ORDER

The Referee's order dated February 23, 1987 is affirmed as supplemented. Claimant's attorney is awarded $500 for services on Board review, to be paid by the SAIF Corporation.

GEORGEANNE M. SAYRE, Claimant
Malagon & Moore, Claimant's Attorneys
E. Jay Perry, Defense Attorney
William J. Blitz (SAIF), Defense Attorney

WCB 86-12720 & 86-13024
February 25, 1988
Order on Review

Reviewed by Board Members Ferris and Crider.

Crawford and Company requests review of those portions of Referee Baker's order that: (1) assessed penalties and attorney fees for its failure to pay interim compensation and its unreasonable compensability denial of claimant's "new injury" claim for a low back condition; and (2) declined to apportion the penalties and attorney fees between Crawford and Company and the SAIF Corporation, which had denied responsibility for claimant's aggravation claim for the same condition. On review, the issues are penalties and attorney fees.

The Board affirms the order of the Referee.

Furthermore, since penalties and attorney fees are not considered compensation, claimant is not entitled to attorney fees for services on Board review. Saiville v. EBI Companies, 81 Or App 469, rev den 302 Or 461 (1986); see also Dotson v. Bohemia, Inc., 80 Or App 233, 236, rev den 302 Or 35 (1986).

ORDER

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

DANIEL A. SHEA, Claimant
David J. Hollander, Claimant's Attorney

Own Motion 88-0036M
February 25, 1988
Own Motion Order

The insurer has submitted to the Board claimant's claim for an alleged worsening of his April 7, 1978 industrial injury. Claimant's aggravation rights have expired. Claimant strained his low back on July 15, 1987. Both the above injuries are currently pending in the Hearings Division for a responsibility decision from the Referee. Claimant asks that the own motion request be consolidated with the pending hearing requests for hearing.

Claimant's request for consolidation of the matters must be denied for two reasons. Claimant's own motion request does not qualify for relief under ORS 656.278 in that no surgery or hospitalization for treatment is contemplated. See also OAR 438-12-052(2). With no entitlement to time loss benefits, the only issues left are soley within the jurisdiction of the Referee. We conclude the request for remand to the Hearings Division and the request for own motion relief must be denied.

IT IS SO ORDERED.

THOMAS J. STOKES, Claimant
Roll, et al., Claimant's Attorneys
Schwabe, et al., Defense Attorneys

Own Motion 87-0754M
February 25, 1988
Own Motion Order

Claimant has requested that the Board exercise its own motion authority and reopen his claim for an alleged worsening of his February 6, 1976 industrial injury. Upon closure, claimant asks that he be granted an award for permanent total disability. Claimant's aggravation rights have expired. The insurer opposes the relief claimant seeks.

Claimant seeks temporary total disability compensation from March 5, 1986 through April 17, 1987. The evidence indicates that claimant last performed gainful employment in August 1985. Claimant contends he was unable to work past that time due to the effects of his injury. Case law indicates that an injured worker must be working or looking for work to be entitled to the payment of temporary total disability compensation. Cutright v. Weyerhaeuser Company, 299 Or 290 (1985), and Karr v. SAIF, 77 Or App 250 (1986). The request for temporary total disability compensation must be denied.

Under the new law, which became effective January 1, 1988, permanent disability benefits can no longer be awarded after the aggravation period has expired. ORS 656.278(1)(a) and OAR 438-12-052(2). Claimant's request for permanent total disability must also be denied.

IT IS SO ORDERED.

TOMMY L. TRONSON, Claimant
Ginsburg, et al., Claimant's Attorneys
David B. Smith (SAIF), Defense Attorney

WCB 87-11240
February 25, 1988
Order Withdrawing Order of Dismissal

On February 10, 1988, we dismissed the SAIF Corporation's request for Board review of the Referee's December 30, 1987 order. We found the January 29, 1988 request for review to be untimely because it was received on February 1, 1988 and was neither mailed by registered nor certified mail. We relied on OAR 438-05-046(1)(b), which establishes a presumption that a request received under these circumstances is untimely unless the filing party establishes that the mailing was timely.

Since the date of our dismissal order, we have received SAIF's January 29, 1988 request for Board review which had been submitted to our Portland office. This request carries the Portland office's date stamp indicating that the request was received on January 29, 1988.

"Filing" means the physical delivery of a thing to any permanently staffed office of the Board, or the date of mailing.

OAR 438-05-046(1)(a). Because SAIF filed its request by physical delivery to a permanently staffed office of the Board, the presumption contained in OAR 438-05-046(1)(b) does not apply. Therefore, the record now establishes that SAIF's request for Board review was timely filed on January 29, 1988, the thirtieth day after the Referee's December 30, 1987 order. See ORS 656.289(3). Furthermore, as noted in our prior order, SAIF timely mailed copies of its January 29, 1988 request to all parties to the proceeding in compliance with ORS 656.295(2). See Argonaut Insurance v. King, 63 Or App 847, 852 (1983).

Inasmuch as SAIF timely requested Board review of the Referee's order and timely mailed notice of its request to all parties, we conclude that we have jurisdiction. See ORS 656.289(3); 656.295(2); Argonaut Insurance v. King, supra. Accordingly, our February 10, 1988 dismissal order is withdrawn.

Upon issuance of this order, a hearing transcript shall be ordered. Once copies of the transcript are forwarded to the parties, a briefing schedule will be implemented.

IT IS SO ORDERED.

CONNIE R. WALKER, Claimant
Carney, et al., Claimant's Attorneys
Schwabe, et al., Defense Attorneys

WCB 87-06330
February 25, 1988
Order Denying Motion to Dismiss

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

The Referee's order issued on December 10, 1987. This order contained a statement explaining the parties' rights of appeal under ORS 656.289 and 656.295. Thereafter, claimant, over the employer's objection, requested an amendment to the order.

On January 8, 1988, the Referee allowed claimant's request and issued an "Amended Order." This order, which specifically amended the December 10, 1987 order, also contained a statement explaining the parties' rights of appeal. On January 26, 1988, the employer requested Board review of the Referee's orders.

A Referee's order is final unless, within 30 days after the day 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's December 10, 1987 order had directed the employer to pay claimant 25 percent of the difference between $559.27 and the unpaid amounts due to a hospital from the employer's group health insurance carrier through April 25, 1986. On January 8, 1988, after considering claimant's request for, and the employer's objection to, an amendment of the prior order, the Referee specifically amended the December 10, 1987 order. The

employer was directed to pay claimant 25 percent of the amount which was payable to the hospital from the employer under the health insurance aspect of its Long Term Disability Plan through April 25, 1986.

The Referee's January 8, 1988 order neither abated, stayed, nor withdrew the December 10, 1987 order. However, the prior order was expressly modified by the January 8, 1988 order before the 30-day appeal period from the prior order had elapsed. Thus, the Referee had jurisdiction to issue the January 8, 1988 Amended Order, including a statement explaining the parties' 30-day appeal rights from the date of the order. Because the employer requested Board review within 30 days of the Amended Order, we have jurisdiction to consider this matter.

Accordingly, the employer's motion to dismiss is denied. Claimant's cross-request for Board review is acknowledged.

IT IS SO ORDERED.

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

WCB 86-08304
February 29, 1988
Amended Order on Reconsideration

The formerly self-insured employer's counsel seeks Board authorization of a client-paid fee for services apparently rendered in response to claimant's motion which eventually culminated in our January 29, 1988 Order on Reconsideration.

After review of the statement of services and attorney retainer agreement submitted by the employer's counsel and considering the factors set forth in OAR 438-15-010(6), we approve a client-paid fee, not to exceed $79.00. In addition, we approve the employer's counsel's request for an estimated fee for additional legal services, not to exceed three hours at the hourly rates listed in the attorney retainer agreement.

Accordingly, our January 29, 1988 Order on Reconsideration is abated and withdrawn. As amended herein, we adhere to and republish our January 29, 1988 order in its entirety. The parties' rights of appeal shall run from the date of this order.

IT IS SO ORDERED.

MARCO AGUIAR, Claimant
Kenneth D. Peterson, Claimant's Attorney
Meyers & Terrall, Defense Attorneys

WCB 84-05596
March 2, 1988
Second Order on Remand

Claimant requested reconsideration of the Board's January 7, 1988 Order on Remand that failed to award attorney fees concerning his counsel's efforts before the Board and the Court of Appeals for prevailing against the self-insured employer's partial denial of his right foot surgery and in obtaining the reopening of his claim. Specifically, claimant asserts entitlement to attorney fees in the following amounts: (1) 25 percent of the increased temporary total disability compensation, not to exceed $750, created by the premature claim closure finding; (2) $925 for services at the Board level concerning the compensability issue; and (3) $1,825 for representation at the Court of Appeals level concerning the compensability issue.

To allow sufficient time to consider the motion, we withdrew our order and requested a response from the employer. After receiving that response and completing our further review of this matter, we are prepared to address claimant's contentions.

The relevant facts are as follows. A Referee set aside the employer's partial denial of claimant's proposed right foot surgery and awarded a reasonable carrier-paid attorney fee of $1,200. However, the Referee did not find the claim to have been prematurely closed. Both parties requested Board review. The Board agreed that the claim had not been prematurely closed. Marco Aguiar, 38 Van Natta 413 (1986). In addition, finding the proposed surgery neither reasonable nor necessary, it reversed those portions of the Referee's order that had set aside the partial denial and awarded an attorney fee.

Claimant appealed. The Court of Appeals reversed the Board's order 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." Aguiar v. J.R. Simplot Company, 87 Or App 475, 479 (1987). Thereafter, acknowledging that his request was "one day late," claimant submitted a petition for attorney fees with the Court of Appeals. See Rule 11.10 Oregon Appellate Rules of Procedure. On December 8, 1987, Chief Judge Joseph issued an order denying the petition.

On January 7, 1988, we issued our Order on Remand. Pursuant to the court's instructions, the Referee's order setting aside the partial denial and awarding the $1,200 attorney fee was reinstated. In addition, the May 15, 1984 Determination Order was rescinded as premature. Finally, the claim was remanded to the employer for processing according to law.

In all cases involving accidental injuries where a claimant finally prevails in an appeal to the Court of Appeals or petition for review to the Supreme Court from an order or decision denying the claim for compensation, the court shall allow a reasonable attorney fee to the claimant's attorney. ORS 656.386(1). In all other cases, attorney fees shall continue to be paid from claimant's award of compensation except as otherwise provided in ORS 656.382.

Claimant contends that he is entitled to attorney fee awards for prevailing finally against the partial denial "at the Board level" and for obtaining the reopening of his claim. We disagree.

Here, claimant did not finally prevail at the Board level. Instead, he finally prevailed against the Board's order upholding the denial of his proposed surgery before the Court of Appeals. Therefore, pursuant to ORS 656.386(1), the court was authorized to allow a reasonable attorney fee for the services rendered by claimant's counsel in overturning the denial. In fact, claimant petitioned the court for such a fee. Yet, his petition was denied.

Claimant also relies on ORS 656.388(1), which provides that "[I]n cases in which a claimant finally prevails after remand

from the Supreme Court, Court of Appeals or board, then, the referee, board or appellate court shall approve or allow a reasonable attorney fee for services before every prior forum." However, this provision is expressly applicable to those cases "in which a claimant finally prevails after remand." As discussed above, rather than finally prevailing after remand to the Board, claimant finally prevailed before the Court of Appeals.

Claimant accurately notes that the Board's rules provide for attorney fees of 25 percent of any increased award of temporary or permanent disability granted by the court following a claimant's request for judicial review. See OAR 438-15-060(1); former rule OAR 438-47-045(1) (Repealed, January 1, 1988). Yet, these rules establish the amount of, rather than the underlying entitlement to, a fee. Without express directions from the court on remand, the Board lacks authority to grant such an award.

Here, the Board received several specific instructions from the court, none of which concerned the award of attorney fees for claimant's attorney's services regarding the partial denial and premature closure issues at either the Board or Court of Appeals' level. In essence, our function was ministerial. Consequently, we conclude that we lack jurisdiction to award attorney fees as requested by claimant.

Accordingly, the request for reconsideration is granted and our prior order withdrawn. On reconsideration, as supplemented herein, we adhere to and republish our January 7, 1988 order, effective this date.

IT IS SO ORDERED.

FRANKLIN BROWN, Claimant
Galton, et al., Claimant's Attorneys
Schwabe, et al., Defense Attorneys

WCB 86-08044
March 2, 1988
Order on Review

Reviewed by Board Members Ferris and Crider.

The insurer requests review of those portions of Referee Fink's order which: (1) set aside its partial denial of claimant's medical services claim for current chiropractic treatment for a low back injury; and (2) increased claimant's unscheduled permanent disability award for a low back injury from 15 percent (48 degrees), as awarded by Determination Order, to 25 percent (80 degrees). The issues are medical services and extent of unscheduled disability. Claimant did not file a brief on review.

We reverse that portion of the order which set aside the partial denial of medical services.

Claimant, a 33-year-old industrial cleaner, compensably injured his low back in July 1985 when he was thrown from a power jack. He was diagnosed as having a severe lumbar strain/sprain with myofascitis. A subsequent CT scan revealed a herniated L5-S1 disc with left nerve root impingement. Dr. Ferrante, a chiropractor, took claimant off work and began conservative treatment three times per week.

On October 1, 1985, claimant was examined by Dr. Puziss,

an orthopedic physician. Claimant told the doctor that his back pain sometimes increased after Dr. Ferrante's manipulations. Dr. Puziss noted probable functional overlay and some chronic irritation in claimant's low back due to the manipulations.

On December 3, 1985, claimant was examined by Dr. Gripekoven, an orthopedic physician. Dr. Gripekoven recommended continued conservative treatment, but felt that forceful manipulation should be avoided in light of the herniated disc.

On December 6, 1985, Dr. Ferrante wrote that his treatment is "justifiable to the recovery process" because it protected claimant from further injury and minimized the extent of his permanent impairment. Dr. Ferrante subsequently reported that he was treating claimant with light manipulation and ultrasound.

Dr. Puziss reviewed Dr. Gripekoven's report and Dr. Ferrante's notes and, on March 6, 1986, opined that further chiropractic treatment was not reasonable and necessary. He added that palliative chiropractic treatments might be useful for two more months if claimant received significant symptomatic relief for at least a week.

On April 1, 1986, claimant was examined by Dr. Fabricius, a chiropractor. She saw no objective evidence warranting further chiropractic treatment, adding that the treatment would be palliative at best and give very temporary relief. Drs. Puziss and Gripekoven concurred. On May 23, 1986, the insurer denied claimant's medical services claim for "continuing chiropractic treatment."

On July 22, 1986, Dr. Ferrante reiterated that his treatment objective was to protect against further injury and minimize permanent disability. He explained that manipulation to the herniated disc retracts the nucleus pulposis and decreases pressure against the nerve. He added that claimant could return to modified work.

On July 22, 1986, Dr. Gripekoven examined claimant for a second time. Claimant informed the doctor that he received momentary relief from Dr. Ferrante's adjustments but that it did not last for any extended period of time. Dr. Gripekoven opined that further treatment could only be palliative.

On July 29, 1986, Dr. Puziss reexamined claimant. Dr. Puziss noted severe functional interference with the examination and found, partially as a result of the interference, that claimant's subjective complaints were not confirmed by any objective findings. Dr. Puziss opined that further treatment was unnecessary and undesirable because it offered only temporary relief and claimant had become dependent on treatment. Dr. Puziss believed the functional overlay was indicative of some hysteria or hypochondriasis. He felt that further treatment would merely reinforce this behavioral problem and not help claimant return to work.

The claim was closed by Determination Order on August 29, 1986 with an award of 15 percent unscheduled permanent disability. Claimant continued to see Dr. Ferrante once per week as of December 1986. Ferrante noted that claimant may, as a result of his spinal impairment, experience recurrent symptomatic episodes requiring a "short corrective phase."

On March 2, 1987, Dr. Fabricius reviewed unspecified documents and opined that, by the time of her first evaluation in May 1986, chiropractic treatment was not necessary to maintain claimant's condition at a status quo, but rather, offered mere temporary relief of pain. She also opined that further treatment was counterproductive because claimant had grown dependent on treatment, resulting in decreased physical function.

On March 6, 1987, Dr. Gripekoven responded to interrogatories from the employer's attorney, indicating that, when he evaluated claimant in December 1985, claimant's ongoing treatment: (1) was not of a curative nature; (2) was not significantly affecting his ability to function physically beyond the level of merely making him feel good; and (3) was not necessary to maintain his condition at a status quo. He added that claimant was probably becoming psychologically dependent on treatment.

On March 17, 1987, Dr. Puziss reviewed unspecified documents received from the employer's attorney and concluded that claimant did not need chiropractic care after May 1, 1986. He added that chiropractic care was counterproductive because claimant was becoming dependent on such care.

Claimant testified that he has continuous low back pain and that his back will give out occasionally without warning. He further testified that he continues to treat with Dr. Ferrante once to twice per month and that the treatments relieve his symptoms temporarily. The period of relief varies unpredictably. He feels that his condition has improved since treating with Dr. Ferrante. He attempted to return to work for the employer on two occasions but could not do the work due to pain. The Referee stated that he was a "little ambivalent" about claimant's credibility after observing his demeanor.

After reviewing the evidence, the Referee concluded that claimant was entitled to receive chiropractic treatment not exceeding twice per month. On review, the employer contends that claimant failed to sustain his burden of proving that chiropractic treatment after May 23, 1986 was reasonable and necessary. We agree.

For his compensable injury, claimant is entitled to medical services "for such period as the nature of the injury or the process of the recovery requires." ORS 656.245(1). Medical expenses are compensable provided that they are reasonably and necessarily incurred in the treatment of the compensable injury. West v. SAIF, 74 Or App 317, 320 (1985); McGarry v. SAIF, 24 Or App 883, 888 (1976). Claimant bears the burden of proving that the treatment is reasonable and necessary. James v. Kemper Ins. Co., 81 Or App 80, 81 (1986).

Dr. Ferrante, claimant's treating chiropractor, was the only physician to opine that continuing chiropractic treatment was reasonable and necessary. He explained that manipulation retracts the herniated disc and relieves pressure on the impinged nerve, thereby protecting claimant from further injury and minimizing his permanent disability. The treating physician's opinion is generally entitled to greater weight, absent persuasive reasons to the contrary. Weiland v. SAIF, 64 Or App 810, 814 (1983). We find persuasive reasons not to give Dr. Ferrante's opinion greater weight in our determination.

Dr. Ferrante produced no objective evidence that claimant has received any material benefit, of either a palliative or curative nature, from his treatment. Although claimant testified that his condition has improved since treating with Dr. Ferrante, other evidence belies that assertion. Claimant receives only temporary relief from treatment, with the period of relief varying unpredictably. Also, the treatment apparently does not enable claimant to work. See West v. SAIF, supra, 74 Or App at 321.

Indeed, the weight of the evidence established that continuing chiropractic treatment was detrimental. All three consulting physicians agreed that claimant was becoming psychologically dependent on Dr. Ferrante's treatments. Dr. Fabricius opined that claimant's dependency was resulting in decreased physical function. Dr Puziss persuasively explained that the significant functional overlay, exhibited by claimant during examinations, evidenced an element of hysteria or hypochondriasis, which is reinforced by further treatment. He concluded that further reinforcement of this behavioral problem would not get claimant back to work.

Given the lack of material benefit from continuing chiropractic treatment, we find that it was not reasonable and necessary to the process of claimant's recovery from his injury. Accordingly, we conclude that treatment after May 23, 1986 was not compensable.

For the purpose of clarification, we emphasize that our decision to uphold the insurer's partial denial does not foreclose claimant's future exercise of his right to medical services that are reasonably and necessarily incurred in the treatment of his compensable injury. ORS 656.245(1); West v. SAIF, supra.

The remainder of the Referee's order is affirmed.

Furthermore, we find that the extent of unscheduled disability issue is of ordinary difficulty with the usual probability of success for claimant. Accordingly, a reasonable attorney fee is awarded.

ORDER

The Referee's order dated April 6, 1987 is reversed in part and affirmed in part. The insurer's partial denial, dated May 23, 1986, is reinstated. The Referee's attorney fee award on the partial denial issue is disallowed. Claimant's attorney is awarded $100 for services on Board review concerning the extent of permanent disability issue, to be paid by the insurer.

RAMONA STECKMANN, Claimant
Constance Wold, Defense Attorney

WCB 86-08870
March 2, 1988
Order on Review

Reviewed by Board Members Crider and Johnson.

Claimant, pro se, requests review of Referee Neal's order that awarded claimant 10 percent (32 degrees) unscheduled permanent disability for an upper back condition, in lieu of a Determination Order that awarded no permanent disability. 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 extent of unscheduled permanent disability.

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

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

ORDER

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

HAROLD D. TALLENT, Claimant
Davis, Bostwick, et al., Defense Attorneys

WCB 85-09741
March 2, 1988
Order on Review

Reviewed by Board Members Crider and Johnson.

The insurer requests review of Referee Lipton's order that declined to allow an offset for an alleged overpayment. On review, the insurer reiterates its request for permission to apply the offset or, alternatively, asks that the case be remanded for further evidence on the amount of the overpayment. Claimant is unrepresented on review.

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 are not persuaded that the record has been improperly, incompletely or otherwise insufficiently developed. Furthermore, we find that the additional evidence regarding the amount of the overpayment was obtainable with due diligence at the time of the hearing. Accordingly, we conclude that remand is not warranted and affirm the order of the Referee.

The Board affirms the order of the Referee.

ORDER

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

HARLENE A. LLOYD, Claimant
Olson Law Firm, Claimant's Attorney
Roberts, et al., Defense Attorneys

WCB 86-05744
March 7, 1988
Order on Review

Reviewed by Board Members Crider and Ferris.

Claimant requests review of those portions of Referee Tenenbaum's order that: (1) assessed a 7.5 percent penalty for a late payment of permanent partial disability pursuant to a Determination Order; and (2) declined to assess a penalty and attorney fee for the insurer's late reimbursement of a private insurer's costs. On review, the issues are penalties and attorney fees.

We increase the penalty to be assessed for the insurer's late payment of permanent partial disability. Furthermore, we conclude that the Hearings Division did not have jurisdiction to hear the issue regarding the late reimbursement of the private health insurer; therefore we decline to assess a penalty for the late reimbursement.

In October 1979 claimant injured her left knee. This injury, which was not industrially related, resulted in a December 1979 surgery. On May 17, 1984, while lifting a patient, claimant compensably injured her right knee. In July 1984 an arthroscopic meniscectomy was performed on her right knee.

In January 1985 further surgery was performed on claimant's left knee. The insurer denied compensability of the left knee condition. However, pursuant to a February 19, 1986 Referee's order, the denial was set aside and the insurer was directed to accept and process the left knee claim. This order was not appealed.

Thereafter, a March 19, 1986 Determination Order awarded temporary disability and 15 percent scheduled permanent partial disability for loss of use of the right leg (knee) and 20 percent scheduled permanent disability for loss of the left leg (knee).

The parties stipulated that the first payment of permanent disability for $2248.44 was not issued until April 24, 1986. Shortly thereafter, the claim was reaudited by the Evaluation Division which found that claimant had been underpaid $1287.52. The insurer resolved this underpayment on May 6, 1986. On June 26, 1986, the insurer received an itemization from the private health care insurer for reimbursement of its costs. The insurer did not provide reimbursement until November 5, 1986.

The Referee initially assessed a 15 percent penalty against the insurer for late payment of the first permanent disability payment and a penalty of five percent for the second late payment. The Referee declined to assess a penalty for the insurer's late reimbursement of the private health care insurer, reasoning that since ORS 656.313(4) does not define medical services as compensation, there were no amounts due upon which a penalty should be assessed. On reconsideration, the Referee reduced the penalty for the first late payment to 7.5 percent.

We modify the Referee's assessment of penalties concerning the first late payment of permanent disability compensation and affirm the Referee's refusal to assess a penalty for late reimbursement of the private health care insurer, but on other grounds.

Permanent disability benefits are timely paid when paid no

later than the 30th day after the date of a Determination Order. OAR 436-60-150(5). The parties agree that the first payment of permanent disability compensation was five days late.

In Richard L. Wine, 39 Van Natta 49 (1987), the Board considered assessing penalties for late payment of permanent disability pursuant to the Board's Own Motion Determination. In Wine, the claimant's payment was one week late. Since the insurer had offered no explanation for the late payment, the Board ordered SAIF Corporation to pay a 25 percent penalty. In George J. Kovarik, 38 Van Natta 1381 (1986), the Board discussed late payment of interim compensation and concluded that the length of the unexplained delay should be considered in setting the percentage factor of the penalty so that the punishment "fits the crime."

Here, the insurer has provided no explanation for the late payment of claimant's permanent partial disability. Based on our de novo review of the evidence in conjunction with the administrative rule, we conclude that a 15 percent penalty on the first payment of permanent disability is a more appropriate penalty.

We turn to the jurisdictional issue concerning the insurer's failure to promptly reimburse claimant's private health care insurer. ORS 656.283(1) provides, inter alia: "Any party or the director may at any time request a hearing on any question concerning a claim." (Emphasis added.) A "claim" is defined as "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 Petshow v. Ptld. Bottling Co., 62 Or App 614, 617 (1983).

We conclude that the dispute regarding the late reimbursement of the private health care insurer is not a matter concerning a claim or a worker's right to compensation, or the amount thereof. Accordingly, the Hearings Division lacked jurisdiction to consider the issue.

ORDER

The Referee's Order on Reconsideration dated March 17, 1987 is modified in part. We modify the Referee's order to assess a penalty of 15 percent against the first late payment of permanent disability compensation. The remainder of the order is affirmed, as supplemented.

ANDREW W. BARRESSE, Claimant
Sharp & Durr, Claimant's Attorneys
SAIF Corp Legal, Defense Attorney

WCB 86-02826
March 8, 1988
Order of Dismissal (Remanding)

Claimant has requested Board review of Referee Bethlahmy's January 15, 1988 order. Claimant's request was filed February 16, 1988. See ORS 438-05-046. Inasmuch as February 14, 1988 was a Sunday and February 15, 1988 was a legal holiday, the request was timely. See ORS 174.120. However, on February 8, 1988, Referee Bethlahmy had issued an Order of Abatement.

Since the Referee abated her order prior to claimant's request for Board review, we lack jurisdiction to consider the issues raised in the request. Accordingly, the request for Board review is dismissed as premature. This matter is remanded to Referee Bethlahmy for further action.

IT IS SO ORDERED.

RODGER L. GAINES, Claimant
Quintin B. Estell, Claimant's Attorney
Gary Wallmark (SAIF), Defense Attorney
Kevin L. Mannix, Defense Attorney

WCB 86-08172 & 86-08173
March 8, 1988
Amended Order on Review

The insurer's counsel seeks Board authorization of a client-paid fee for additional legal services "since [the] last accounting cycle" in this matter, which the insurer's counsel estimates were rendered in connection with our February 10, 1988 Order on Review.

After review of the statement of services and attorney retainer agreement submitted by the insurer's counsel, and considering the factors set forth in OAR 438-15-010(6), we approve a client-paid fee, not to exceed $300.00.

Accordingly, our February 10, 1988 order is abated and withdrawn. As amended herein, we adhere to and republish our February 10, 1988 order in its entirety. The parties' rights of appeal shall run from the date of this order.

IT IS SO ORDERED.

RONALD E. LOWERY, Claimant
SAIF Corp Legal, Defense Attorney

Own Motion 88-0070M
March 9, 1988
Own Motion Order

SAIF Corporation has submitted to the Board claimant's claim for an alleged worsening of his June 9, 1978 industrial injury. Claimant's aggravation rights have expired. Claimant specifically seeks an additional award for permanent partial disability. SAIF opposes the relief claimant seeks.

Under the new law, which became effective January 1, 1988, permanent disability benefits can no longer be awarded. ORS 656.278(1)(a) and OAR 438-12-052(2). The Board must deny the request for own motion relief.

IT IS SO ORDERED.

RENA E. PHIBBS, Claimant
Martin McKeown, Claimant's Attorney
SAIF Corp Legal, Defense Attorney

Own Motion 88-0076M
March 9, 1988
Own Motion Order

SAIF Corporation has submitted to the Board claimant's claim for an alleged worsening of her October 2, 1980 industrial injury. Claimant's aggravation rights have expired. SAIF opposes reopening of this claim as it contends claimant's request does not qualify under the current own motion law.

Under the new law, which became effective January 1, 1988, temporary total disability benefits may be allowed only when the injured worker is hospitalized for treatment or undergoes surgery. ORS 656.278(1)(a) and OAR 438-12-052(2). Neither has taken place in this case. The request for own motion relief must be denied.

IT IS SO ORDERED.

ROBERT D. JACKSON, Claimant
Tooze, Marshall, et al., Defense Attorneys

WCB 85-08850
March 10, 1988
Amended Order on Review

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

After review of the statement of services and attorney retainer agreement submitted by the insurer's counsel and considering the factors set forth in OAR 438-15-010(6), we approve a client-paid fee, not to exceed $874.

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

IT IS SO ORDERED.

DAREN H. DEAN, Claimant
Imperati, et al., Claimant's Attorneys
Mark Bronstein (SAIF), Defense Attorney

WCB 86-08300
March 11, 1988
Amended Order on Review

Reviewed by Board Members Crider and Johnson.

Claimant's counsel seeks Board authorization of an assessed fee for services rendered on review which culminated in our February 25, 1988 Order on Review.

After reviewing the statement of services submitted by claimant's counsel and considering the factors set forth in OAR 438-15-010(6), we approve an assessed fee in the amount of $650.

Accordingly, our February 25, 1988 order is abated and withdrawn. As amended herein, we adhere to and republish our February 25, 1988 order in its entirety. The parties' rights of appeal shall run from the date of this order.

IT IS SO ORDERED.

WADE A. DOAK, Claimant
W.D. Bates, Jr., Claimant's Attorney
Brian L. Pocock, Defense Attorney

WCB 86-09423
March 11, 1988
Amended Order on Review

Reviewed by Board Members Crider and Johnson.

The self-insured employer's counsel seeks Board authorization of a client-paid fee for services rendered on review which culminated in our February 10, 1988 Order on Review.

After review of the statement of services and attorney retainer agreement submitted by the employer's counsel and considering the factors set forth in OAR 438-15-010(6), we approve a client-paid fee, not to exceed $455.00.

Accordingly, our February 10, 1988 order is abated and withdrawn. As amended herein, we adhere to and republish our February 10, 1988 order in its entirety. The parties' rights of appeal shall run from the date of this order.

IT IS SO ORDERED.

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

WCB 87-04131
March 11, 1988
Order on Review

Reviewed by Board Members Ferris and Johnson.

The insurer requests review of those portions of Referee Nichols' order that: (1) set aside its "de facto" denial of claimant's request for authorization for neck surgery as relates to the C6-7 level; and (2) assessed an attorney fee for untimely denial of medical services relating to the C3-4 and C5-6 levels. With its brief, the insurer has submitted numerous documents not admitted into the record at hearing. We treat these submissions as a request for remand. The issues are medical services, attorney fees, and remand.

We first note that we have no authority to consider evidence not admitted at hearing and not a part of the record. Groshong v. Montgomery Ward Co., 73 Or App 403, 406 (1985). We may remand to the Referee if we find that the record has been "improperly, incompletely or otherwise insufficiently developed." ORS 656.295(5). The insurer argues that the Referee improperly excluded the documents in question. We find, however, that the documents were excluded by agreement of the parties. Furthermore, we find that the record is completely and sufficiently developed without the proferred evidence. The insurer's request for remand is denied.

The insurer also asserts that the doctrine of res judicata should have been applied by the Referee in order to prevent claimant from litigating the compensability of the proposed surgery. The insurer contends that the issue could have been litigated in a prior hearing. See Million v. SAIF, 45 Or App 1097, 1102 (1980).

We note as a preliminary matter that this case has been through numerous hearings and appeals. We refer only to those facts necessary for a determination of the issues before us.

On August 8, 1986, Dr. Smith, neurological surgeon, performed a diskogram on claimant. Dr. Smith opined in his post-surgery report that "any rationale surgical approach to [claimant's problem] ... should be in the form of decompression at the C-6 root, and possibly the C-7 root..." He concluded his report by stating that claimant would remain in contact "with respect to request for authorization for posterior cervical laminectomy, decompression at C5-6 and C6-7."

Claimant testified that Dr. Smith forwarded this report to the insurer. No evidence to the contrary was offered. We find that the report was, in fact, a request for authorization which was received by the insurer sometime after August 8, 1986.

A prior hearing was held in this case on November 26, 1986. The date of this hearing is 110 days following Dr. Smith's request for authorization of surgery. The insurer had not formally accepted or denied the surgery request as of the date of the prior hearing. We, therefore, find that the claim was effectively in denied status prior to that hearing. See ORS 656.262(6); Joyce A. Morgan, 36 Van Natta 114, 117-18, aff'd mem 70 Or App 616 (1984). We conclude that the surgery claim was ripe for adjudication at the time of the prior hearing.

Our inquiry does not end here, however. The next question is whether claimant's claim for surgery was part of the same "cause of action" as was involved in the prior hearing. The Court of Appeals has defined "a cause of action" as:

> "[A]n aggregate of operative facts which compose a single occasion for judicial relief; the number of operative facts that should be viewed as included within a single cause of action must be determined pragmatically, on the basis primarily of practical trial convenience considerations." Carr v. Allied Plating Co., 81 Or App 306 (1986).

It is thus apparent that the fact the prior hearing and claimant's surgery request involve claims resulting from the same injury is not determinative. The inquiry instead requires a pragmatic approach based primarily upon practical trial convenience considerations.

The issues at the earlier hearing involved payment of previously incurred medical bills, penalties and attorney fees for nonpayment of medical bills pursuant to Orders pending appeal, and penalties and attorney fees for an alleged improper denial of a change of physicians. These issues essentially involve claims-processing type questions. None of these issues require a determination of causation.

By contrast, claimant's request for surgery directly involves compensability considerations requiring expert medical evidence. Furthermore, the surgery request was not in "de facto" denied status until mid-October at the earliest. The prior hearing was held in November. This left the parties approximately one month to gather the required evidence. In Carr, supra, the court concluded that a one-to-two month period within which to gather medical evidence militated against application of the res judicata doctrine. 81 Or App at 310. We also note that as late as ten months following the prior hearing each of the parties was still attempting to ascertain the position of the other with regard to the proposed surgery. We conclude that, given the posture of this case, the surgery request in August 1986 did not involve the same set of operative facts as was involved at the November 1986 hearing. We, therefore, decline to apply the doctrine of "res judicata" to bar claimant's claim for surgery.

Having concluded that claimant's surgery request was not barred by application of the doctrine of res judicata, we affirm the Referee's order.

Claimant's counsel seeks Board authorization of an assessed fee for services rendered on Board review. After review of the statement of services and attorney retainer agreement submitted by claimant's counsel and considering the factors set forth in OAR 438-15-010(6), we award an assessed fee of $1,500.

ORDER

The Referee's order dated November 6, 1987 is affirmed. Claimant's counsel is awarded $1,500 as a reasonable attorney fee, to be paid by the insurer.

ALICIA OSEGUERA, Claimant
Biel, et al., Claimant's Attorneys
Meyers & Terrall, Defense Attorneys

WCB 86-17204
March 11, 1988
Amended Order on Review

Reviewed by Board Members Crider and Johnson.

The insurer's counsel seeks Board authorization of a client-paid fee for services rendered on review which culminated in our February 10, 1988 Order on Review.

After review of the statement of services and attorney retainer agreement submitted by the insurer's counsel and considering the factors set forth in OAR 438-15-010(6), we approve a client-paid fee, not to exceed $255.50.

Accordingly, our February 10, 1988 order is abated and withdrawn. As amended herein, we adhere to and republish our February 10, 1988 order in its entirety. The parties' rights of appeal shall run from the date of this order.

IT IS SO ORDERED.

The Beneficiaries of
DONALD R. STACY (Deceased), Claimant
Lucas & Associates, Claimant's Attorneys
Lester R. Huntsinger (SAIF), Defense Attorney

WCB 87-10911
March 15, 1988
Order Denying Reconsideration

Claimant has requested reconsideration of the Board's February 9, 1988 Order of Dismissal. The request is denied.

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

Inasmuch as the Board's February 9, 1988 order has neither been appealed, abated, stayed, nor republished, it has become final by operation of law. Accordingly, the Board lacks jurisdiction to consider claimant's request.

IT IS SO ORDERED.

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

WCB 86-11759
March 16, 1988
Amended Order on Review

Reviewed by Board Members Crider and Johnson.

The self-insured employer's counsel seeks Board authorization of a client-paid fee for services rendered on review which culminated in our February 25, 1988 Order on Review.

After review of the statement of services and attorney retainer agreement submitted by the employer's counsel and considering the factors set forth in OAR 438-15-010(6), we approve a client-paid fee, not to exceed $105.

Accordingly, our February 25, 1988 order is abated and withdrawn. As amended herein, we adhere to and republish our

February 25, 1988 order in its entirety. The parties' rights of appeal shall run from the date of this order.

IT IS SO ORDERED.

SUSAN A. BAGWELL, Claimant
Jolles, et al., Claimant's Attorneys
SAIF Corp Legal, Defense Attorney

Own Motion 87-0424M
March 16, 1988
Own Motion Order

SAIF Corporation initially submitted to the Board claimant's claim for an alleged worsening of her December 9, 1978 industrial injury. Claimant's aggravation rights have expired. The Board referred the request for own motion relief to the Hearings Division for consolidation with WCB Case Numbers 87-11182 and 87-11733. By Opinion and Order, dated February 2, 1988, Referee Tuhy found SAIF Corporation responsible for claimant's current condition and recommended that the Board exercise its own motion authority and reopen her claim for the payment of disability benefits.

The Board agrees with the Referee's finding that SAIF Corporation is responsible for claimant's current condition. However, we are unable to concur with the recommendation that claimant's SAIF claim be reopened. Claimant's 1978 injury is currently in a closed status and, as such, must be processed by the Board under the current own motion law. Under the new law, which became effective January 1, 1988, temporary total disability benefits may be allowed only when the injured worker is hospitalized for treatment or undergoes surgery. Neither has occurred in this case. The request for own motion relief must, therefore, be denied. ORS 656.278(1)(a) and OAR 438-12-052(2).

IT IS SO ORDERED.

BRYCE D. BRUMMETT, Claimant
Bischoff & Strooband, Claimant's Attorneys
Cowling & Heysell, Defense Attorneys

WCB 86-06567
March 16, 1988
Amended Order on Review

Reviewed by Board Members Johnson and Crider.

The self-insured employer's counsel seeks Board authorization of a client-paid fee for services rendered on review which culminated in our February 19, 1988 Order on Review.

After review of the statement of services and attorney retainer agreement submitted by the employer's counsel and considering the factors set forth in OAR 438-15-010(6), we approve a client-paid fee, not to exceed $600.

Accordingly, our February 19, 1988 order is abated and withdrawn. As amended herein, we adhere to and republish our February 19, 1988 order in its entirety. The parties' rights of appeal shall run from the date of this order.

IT IS SO ORDERED.

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

WCB 87-12941
March 16, 1988
Order of Dismissal

Claimant has requested review of Referee Knudsen's order dated January 22, 1988. Claimant's request, dated February 22, 1988, was received by the Board on February 23, 1988. The request was neither mailed by registered nor certified mail. A certificate of service, submitted with the request, indicated that copies of the request had been mailed to all parties to the proceeding.

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

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

Here, the thirtieth day after the Referee's January 22, 1988 order was February 21, 1988, a Sunday. Therefore, the last day to timely file a request for Board review was Monday, February 22, 1988. See ORS 174.120. However, claimant's request for review was actually received by the Board on February 23, 1988. Since the request was neither mailed by registered nor certified mail and was received after the date for filing, it is presumed to be untimely until claimant establishes that the mailing was timely. See OAR 438-05-046(1)(b).

Under these circumstances, we lack jurisdiction to review the Referee's order. Accordingly, the request for Board review is dismissed.

IT IS SO ORDERED.

STEVEN M. DeMARCO, Claimant
Pozzi, et al., Claimant's Attorneys
SAIF Corp Legal, Defense Attorney

WCB 85-01456
March 16, 1988
Order on Remand

This matter is before the Board on remand from the Court of Appeals. DeMarco v. Johnson Acoustical, 88 Or App 439 (1987). The court has concluded that claimant's upper back and neck condition worsened after November 1, 1984. Consequently, the court has remanded with "instructions to accept the aggravation claim."

Accordingly, the SAIF Corporation's April 19, 1985

denial is set aside and the claim is remanded to SAIF for processing pursuant to law.

IT IS SO ORDERED.

CAROL DENNY, Claimant
Flaxel, et al., Claimant's Attorneys
Foss, et al., Defense Attorneys

WCB 85-15708
March 16, 1988
Order on Remand

This matter is before the Board on remand from the Court of Appeals. Denny v. Hallmark Fisheries, 88 Or App 409 (1987). The court agreed with the Board that claimant had not established a compensable aggravation claim for her left knee condition. However, the court has concluded that claimant's requested left knee surgery is related to her 1982 compensable left knee injury and, thus, compensable under ORS 656.245. Consequently, the court has "remanded for payment of medical benefits."

Accordingly, the insurer's December 11, 1985 denial is set aside insofar as it purported to deny responsibility for surgery on claimant's left knee. The claim is remanded to the insurer for payment of claimant's medical benefits resulting from this surgery.

IT IS SO ORDERED.

ANTHONY D. ELLENA, Claimant
Magar E. Magar, Claimant's Attorney
Mitchell, et al., Defense Attorneys

WCB 85-00709
March 16, 1988
Amended Order on Review

Reviewed by Board Members Johnson and Crider.

The insurer's counsel seeks Board authorization of a client-paid fee for services rendered on review which culminated in our February 22, 1988 Order on Review.

The insurer's counsel failed to submit an attorney retainer agreement. Therefore, pursuant to OAR 438-15-010(1), we cannot assess an attorney fee.

Accordingly, our February 22, 1987 order is abated and withdrawn. As amended herein, we adhere to and republish our February 22, 1987 order in its entirety. The parties' rights of appeal shall run from the date of this order.

IT IS SO ORDERED.

DERYL E. FISHER, Claimant
Emmons, et al., Claimant's Attorneys
Cliff, et al., Defense Attorneys

WCB 83-01466
March 16, 1988
Order on Remand

This matter is before the Board on remand from the Court of Appeals. Pursuant to the court's February 18, 1988 order, we have been instructed to consider for approval the parties' Disputed Claim Settlement. The agreement is designed to resolve all issues raised or raisable in this case.

In consideration of the insurer's promise to pay a stated sum, claimant has agreed that the Board's September 3, 1986 Order on Review shall become final. We have approved the parties'

settlement, thereby fully and finally resolving this case. Accordingly, this matter is dismissed with prejudice.

IT IS SO ORDERED.

THEODULE LEJEUNE, JR., Claimant
Pozzi, et al., Claimant's Attorneys
Roberts, et al., Defense Attorneys

WCB 86-12737
March 16, 1988
Amended Order of Dismissal

The insurer's counsel seeks Board authorization of a client-paid fee for services rendered in this matter, which resulted in the parties' disputed claim settlement, and eventually culminated in our February 25, 1988 Order of Dismissal.

After review of the statement of services and the referral letter in this particular case, as submitted by the insurer's counsel, and considering the factors set forth in OAR 438-15-010(6), we approve a client-paid fee, not to exceed $127.50.

Accordingly, our February 25, 1988 order is abated and withdrawn. As amended herein, we adhere to and republish our February 25, 1988 order in its entirety. The parties' rights of appeal shall run from the date of this order.

IT IS SO ORDERED.

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

WCB TP-87030
March 16, 1988
Third Party Distribution Order

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

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

With SAIF's approval, claimant settled the third party action for $120,000. The settlement was also approved by the Probate Court of the Circuit Court for Clackamas County. The court further ordered that claimant's attorney receive $40,000 of the settlement for attorney fees and $8,368.01 for litigation costs. Claimant was directed to deposit the remaining balance of the settlement in a separate interest-bearing account pending final distribution.

Following deduction of claimant's attorney fees and costs, the settlement's remaining balance totalled $81,631.99. After reducing the remaining balance by the statutory one-third share under ORS 656.593(3) and 656.593(1)(b), the amount of the settlement subject to SAIF's statutory lien equals $54,421.32.

SAIF's lien for its actual costs currently totals $67,647.37. Because SAIF's actual costs exceed its maximum distributive statutory share from the remaining balance of the settlement, SAIF does not assert a lien for future expenditures.

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

Pursuant to ORS 656.578, if a worker receives a compensable injury due to the negligence or wrong of a third person, entitling the worker under ORS 656.154 to seek a remedy against such third person, such worker or, if death results from the injury, the other beneficiaries shall elect whether to recover damages from the third person. If the worker or the beneficiaries of the worker elect to recover damages from the third person, notice of such election shall be given to the paying agency. ORS 656.593(1). The proceeds of any damages recovered from a third person by the worker or beneficiaries shall be subject to a lien of the paying agency. id. The paying agency's lien shall be preferred to all claims except the cost of recovering damages from the third party. ORS 656.580(2).

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

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

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

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

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

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

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

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

Accordingly, we conclude that the following distribution of proceeds from the third party settlement is "just and proper." See ORS 656.593(3). After distribution of claimant's attorney fees of $40,000 and litigation costs of $8,536.38, claimant, on behalf of the deceased worker's estate, is entitled to a statutory 1/3 share of the remaining balance of the settlement's proceeds. ie, $27,210.67. The remaining portion of the settlement's proceeds, $54,421.32, shall be distributed to the SAIF Corporation.

IT IS SO ORDERED.

ROSE J. PETERSON, Claimant
Charles D. Maier, Claimant's Attorney
Gary Wallmark (SAIF), Defense Attorney
Rankin, et al., Defense Attorneys

WCB 86-12839 & 86-12003
March 16, 1988
Second Order of Dismissal of Cross-Request for Board Review

Claimant has requested reconsideration of our December 18, 1987 order which dismissed her cross-request for review as untimely filed. Claimant asserts that she mailed her cross-request for review of the Referee's October 16, 1987 order on November 4, 1987, which was the same day she mailed copies of the cross-request to the opposing parties.

As we acknowledged in our prior order, claimant's cross-request for review was dated November 4, 1987. However, the record fails to establish that the cross-request was mailed to the Board on that day. Rather, the record supports the conclusion that the cross-request was not filed until November 30, 1987, when it was hand-delivered to the Board. Inasmuch as the cross-request was not filed until some 45 days after the Referee's order, we continue to conclude that it is untimely. See ORS 656.289(3). Consequently, the cross-request for Board review is dismissed.

Accordingly, the request for reconsideration is granted. On reconsideration, as supplemented herein, we adhere to and republish our December 18, 1987 order, effective this date.

IT IS SO ORDERED.

SHARON D. STEPHENS, Claimant
Roberts, et al., Defense Attorneys

WCB 86-13748
March 16, 1988
Order Denying Motion to Dismiss

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

The Referee's order issued November 27, 1987. Claimant mailed a letter, dated December 27, 1987, to the Board. In the letter, claimant objected to the Referee's order and expressed her intention to locate another attorney to represent her in filing her appeal. Claimant further represented that copies of her request had been provided to all of the parties. The Board received the request on Monday, December 28, 1987. The insurer represents that neither it nor its counsel received claimant's request for Board review until January 4, 1988.

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

Here, the thirtieth day after the Referee's November 27, 1987 order was December 27, 1987, a Sunday. Therefore, the last day to timely file a request for Board review was Monday,

December 28, 1987. See ORS 174.120; Former OAR 438-05-040(4)(c) (Repealed January 1, 1988, WCB Admin. Order 5-1987). Since claimant's December 27, 1987 request was received by the Board on December 28, 1987, it is timely. See ORS 656.289(3); ORS 656.295(1); Former OAR 438-05-040(4), (Repealed January 1, 1988, WCB Admin. Order 5-1987); Former OAR 438-11-005(2), (Repealed January 1, 1988, WCB Admin. Order 5-1987).

Furthermore, included with claimant's request, was her representation that copies had been sent to the other parties. Counsel for the insurer acknowledges receipt of a copy of the request approximately eight days after the request was mailed to the Board. Under these circumstances, we find that claimant timely mailed a copy of her request for Board review to all parties to the proceeding. See ORS 656.295(2); Argonaut Insurance Co. v. King, supra; Danny R. Akers, 39 Van Natta 732, 813 (1987). Consequently, we conclude that we have jurisdiction to consider her request for review.

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

IT IS SO ORDERED.

TOMAS M. LOPES, Claimant
Welch, et al., Claimant's Attorneys
Kevin Mannix, Defense Attorney

WCB 86-15237
March 17, 1988
Amended Order of Dismissal

The insurer's counsel seeks Board authorization of a client-paid fee for estimated additional legal services rendered subsequent to the date listed in the insurer's counsel prior statement of service, which was submitted along with the parties' stipulation and disputed claim settlement, and eventually culminated in our February 16, 1988 Order of Dismissal.

After review of the statement of services and the retainer agreement, as submitted by the insurer's counsel, and considering the factors set forth in OAR 438-15-010(6), we approve an additional client-paid fee for estimated legal services, not to exceed $300.00.

As amended herein, we adhere to and republish our February 16, 1988 order in its entirety. The parties' rights of appeal shall run from the date of this order.

IT IS SO ORDERED.

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

WCB 87-04966
March 18, 1988
Order of Remand

Claimant requested Board review of a Referee's order which affirmed a March 6, 1987 Determination Order that declined to award permanent disability for a compensable June 2, 1986 head, neck, and back injury. Prior to conducting our review, claimant has asked that this matter be immediately remanded for consolidation with a hearing currently pending before the Hearings Division in WCB Case No. 88-01589. The motion for remand is granted.

The relevant facts are as follows. In June 1987, while his hearing request from the March 1987 Determination Order was pending, claimant sustained another compensable back injury while working for the same employer. The employer was insured by the SAIF Corporation, who is also the insurer in this case.

On August 25, 1987, prior to the October 6, 1987 hearing in this case, claimant's attorney asked SAIF to provide all revelant documents concerning the June 1987 injury. In addition, claimant's attorney specifically requested an "anticipated" medical report from BBV Medical Services (BBV), who, the attorney noted, was scheduled to conduct an examination that day.

That same day, BBV issued a medical report discussing claimant's medical history, including both his 1986 and 1987 compensable back injuries. Anticipating that claimant would become medically stationary in 2 to 3 weeks, BBV further discussed the likelihood of permanent impairment to his cervical, thoracic, and lumbar spine. This medical report was submitted to SAIF.

The August 1987 BBV report was not provided to claimant's attorney prior to the October 6, 1987 hearing. At that time, the most recent medical report concerning claimant's back condition present in the record was a January 24, 1987 BBV medical report. Unaware that the August 1987 report had been supplied to SAIF and not provided to him, claimant raised no objection to the closing of the hearing record.

On November 10, 1987, the Referee affirmed the March 1987 Determination Order, which had declined to award permanent disability for claimant's June 1986 compensable injury. Following claimant's request for Board review from the Referee's order, his counsel received a copy of the August 1987 BBV report. This report was apparently supplied in conjunction with claimant's request for hearing from a Determination Order which issued in regards to the June 1987 compensable back injury. A hearing concerning claimant's request is currently scheduled for April 18, 1988 before the Hearings Division in WCB Case No. 88-01589.

Should we determine that a case has been improperly, incompletely, or otherwise insufficiently developed, we may remand to the Referee for further evidence taking, correction, or other necessary action. ORS 656.295(5). To merit remand, it must be established that the evidence relevant to the issues raised in the remand request was unobtainable with due diligence before the hearing. See Bernard L. Osborn, 37 Van Natta 1054, 1055 (1985), aff'd mem. 80 Or App 152 (1986).

Claimant contends that the omission of the August 1987 BBV report from the present record renders it incompletely developed. Moreover, he submits that the omission of the report from the record was attributable to SAIF's failure to provide him with a copy prior to the hearing. SAIF responds that although claimant's attorney was aware of the report's existence prior to the hearing, he made no "vigorous effort" to obtain it and allowed the record to close without raising an objection. Asserting that the report was obtainable with due diligence before the hearing, SAIF argues that this matter should not be remanded.

After conducting our review of this matter, we are persuaded that the present record, without the inclusion of the

August 1987 BBV report, is insufficiently developed. Furthermore, we find that this omission is directly related to SAIF's failure to timely respond to claimant's attorney's request, which specifically mentioned the "anticipated" medical report from BBV. Under these circumstances, we conclude that the report was unobtainable with due diligence prior to the hearing. To hold otherwise would shift the burden of obtaining a defense-generated report to claimant's counsel when the report was not furnished to counsel even though a demand for the report was made in accordance with OAR 438-07-015(2).

Accordingly, this matter is remanded to the Hearings Division for consolidation with the hearing currently scheduled for April 18, 1988 in WCB Case No. 88-01589. The Referee is instructed to consider the extent of claimant's permanent disability, if any, resulting from his June 2, 1986 compensable injury. In conducting this evaluation, the Referee should consider the existing record, as well as the August 1987 BBV medical report and other documentary and testimonial evidence submitted at the forthcoming hearing. Finally, the Referee should also consider whether SAIF's claims processing in this matter constitutes unreasonable conduct and whether penalties and associated attorney fees are warranted.

ORDER

The Referee's November 10, 1987 order is vacated. This matter is remanded to the Hearings Divsion for consolidation with WCB Case No. 88-01589 and further action consistent with this order.

ELAINE M. BORGELT, Claimant
McMenamin & Associates, Claimant's Attorneys
Liberty Northwest, Defense Attorney

WCB TP-88002
March 21, 1988
Third Party Order

Claimant has petitioned the Board to resolve a dispute concerning a proposed settlement of a third party action. See ORS 656.587. Claimant and the third party have agreed to settle her cause of action for $20,000. The paying agency's lien currently totals $21,701.08.

The paying agency refuses to approve the settlement. It contends that the liability of the third party is undisputed and that complete, or nearly complete, recovery of its lien is attainable if the case proceeds further towards trial.

Pursuant to ORS 656.587, the Board is authorized to resolve disputes concerning the approval of any compromise of a third party action. In exercising this authority, we employ our independent judgment to determine whether the compromise is reasonable. Natasha D. Lenhart, 38 Van Natta 1496 (1986). Generally, we will approve settlements negotiated between a claimant/plaintiff and a third party defendant, unless the settlement appears to be grossly unreasonable. Kathryn I. Looney, 39 Van Natta 1140 (1987), Steven B. Lubitz, 39 Van Natta 809 (1987), Virginia Merrill, 35 Van Natta 251 (1983), Rose Hestkind, 35 Van Natta 250 (1983).

After reviewing this record and applying the aforementioned standards, we find the proposed settlement

reasonable. Consequently, we approve the settlement offer of $20,000. Proceeds of the settlement shall be distributed in accordance with ORS 656.593(1).

IT IS SO ORDERED.

MARIAN S. DUMAS, Claimant
Haugh & Foote, Claimant's Attorneys
Meyers & Terrall, Defense Attorneys

WCB 86-08169
March 21, 1988
Order Denying Request

The insurer's counsel seeks Board authorization of a client-paid fee for services rendered on review which culminated in our January 7, 1988 Order on Review.

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

Inasmuch as the Board's January 7, 1988 order has neither been appealed, abated, stayed, nor republished, it has become final by operation of law. Accordingly, the Board lacks jurisdiction to consider the insurer's counsel's request.

IT IS SO ORDERED.

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

WCB 87-13896
March 21, 1988
Order of Dismissal

The self-insured employer has requested review of Referee Bennett's order dated January 28, 1988. The employer's request, dated February 26, 1988, was received by the Board on March 1, 1988. The request was neither mailed by registered nor certified mail. A certificate of service, submitted with the request, indicated that copies of the request had been mailed to all parties to the proceeding on February 26, 1988.

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

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

Here, the thirtieth day after the Referee's January 28, 1988 order was February 27, 1988, a Saturday. Therefore, the last day to timely file a request for Board review was Monday, February 29, 1988. See ORS 174.120. The employer's February 26, 1988 request for Board review of the Referee's January 28, 1988 order was neither mailed by registered nor certified mail. Since the request was actually received by the Board on March 1, 1988, after the date for filing, it is presumed to be untimely until the employer establishes that the mailing was timely. See OAR 438-05-046(1)(b).

Under these circumstances, we lack jurisdiction to review the Referee's order. Accordingly, the request for Board review is dismissed.

IT IS SO ORDERED.

HARRY A. JOERS, Claimant
Roll, et al., Claimant's Attorneys
Acker, Underwood, et al., Defense Attorneys
Davis, et al., Defense Attorneys

WCB 86-16915 & 86-14634
March 21, 1988
Order on Review

Reviewed by the Board en banc.

Liberty Northwest Insurance Corporation requests review of those portions of Referee Foster's order that: (1) set aside its denial of claimant's "new injury" claim for a low back condition; and (2) upheld Farmers Insurance's denial of "time loss or other benefits" beyond July 21, 1986. Farmers cross-requests review of that portion of the Referee's order that admitted into evidence certain medical reports offered by Liberty, without allowing Farmers an opportunity for cross-examination. The issues are responsibility and evidence.

We reverse on the responsibility issue, but affirm the Referee's evidentiary ruling with a comment.

Claimant, a truck driver, filed a low back injury claim with Farmers' insured in May 1986. Farmers accepted the claim as a nondisabling injury. A few days after the injury, claimant returned to regular work and began treating with Dr. Buttler, chiropractor. Buttler did not consider claimant medically stationary and was unable to estimate the length of further treatment.

On June 1, 1986, Farmers' insured was purchased by Liberty's insured. One month later, claimant was examined by Dr. Grossenbacher, surgeon, for the purposes of an independent medical examination. Grossenbacher opined, inter alia:

> "The [claimant] is not medically stationary at this time. He would be interpreted as medically stationary within the next one to two months."

On July 21, 1986, claimant experienced increased back pain while driving a "semi-sleeper truck." As a result, he discontinued working beyond August 1, 1986. Later that month, claimant was reexamined by Dr. Buttler. Buttler reported that claimant had experienced "a worsening of his condition . . . ." In September 1986, Buttler reported:

> "[Claimant's] work activity from July 21st to August 1st caused his already present lumbosacral sprain and myalgia . . . to become exacerbated. In that he was doing the same activity from July 21st to August 1st that he was doing when he initially was injured, I would say that there was no new intervening injury, but that the activity from July 21st to August 1st contributed to causing his low back condition to exacerbate to the point where he had to be removed from work."

In October 1986, Farmers denied responsibility for claimant's back condition beyond July 21, 1986. In December 1986, Liberty denied both compensability and responsibility for claimant's "current symptoms." Subsequently, by way of a stipulation, Liberty conceded the compensability of claimant's back condition.

In December 1986, claimant was examined on two occasions by Dr. Simpson, orthopedist. On December 11, 1986, Simpson opined that the cause of claimant's back pain "is not entirely apparent." One week later, Simpson reported that claimant's work activities between July 21 and August 1, 1986, independently contributed to his increased back pain.

Claimant testified that although he experienced increased pain in July 1986, his low back symptoms remained unchanged.

The hearing in this case convened in January 1987. A few days prior thereto, Liberty's attorney submitted a medical report from Dr. Buttler, dated September 1986. Liberty's attorney submitted the report within seven days of receipt. The report had originally been solicited by Farmers, but Farmers apparently chose not to submit the report into evidence. The Referee admitted the report into evidence, but declined to leave the record open to allow Farmer's attorney an opportunity to cross-examine Buttler.

Finding that claimant had proven a "new injury," the Referee set aside Liberty's denial and upheld Farmers' denial. We disagree.

Here, claimant's May 1986 claim remained in the open status at the time of his increased back pain in July 1986. Therefore, this case does not present a true "aggravation/new injury" question as in the successive injury line of cases. See e.g. Hensel Phelps Construction v. Mirich, 81 Or App 290, 294 (1986). Both insurers, however, have conceded the issue of compensability. Accordingly, the only question presently before the Board is responsibility.

In Mirich, supra, the court held that the insurer on the risk at the time of the original injury remains responsible, unless there is a finding that work activities at the later employer independently contributed to a worsening of the worker's underlying condition. 81 Or App at 294. Here, only three months had expired between the date of claimant's compensable injury and his increased pain in July 1986. His claim had never been closed. He unequivocally testified that his symptoms did not

change in July 1986; but rather, only became more painful. Moreover, Dr. Buttler opined that "there was no new intervening injury . . . ." (Emphasis added). Buttler first examined claimant shortly after the May 1986 injury. Unlike Buttler, Dr. Simpson did not observe claimant until December 1986. Given Buttler's opportunity to observe claimant both before and after July 1986, we find his opinion persuasive. See Jordan v. SAIF, 86 Or App 29, 33 (1987).

Accordingly, after our de novo review of the lay and medical evidence, we find that claimant's low back condition beyond July 21, 1986, is the continuing responsibility of Farmers.

Lastly, we comment on the Referee's evidentiary ruling. The Referee admitted into evidence a certain medical report authored by Dr. Buttler, which was properly submitted by Liberty's attorney a few days prior to the hearing. The Referee declined, however, to allow Farmers' attorney an opportunity to cross-examine Buttler. Inasmuch as Farmers originally solicited the report from Buttler and apparently had the report in its possession for over three months prior to the hearing, we find no error in the Referee's ruling.

ORDER

The Referee's order dated February 25, 1987, is reversed in part and affirmed in part. Liberty Northwest Insurance Corporation's denial is reinstated and upheld. Farmers Insurance's denial is set aside and this claim is remanded to Farmers for processing according to law. Farmers shall reimburse Liberty for its claim costs incurred to date. All remaining portions of the Referee's order are affirmed as supplemented.

Board Member Crider, dissenting:

I dissent. I would affirm the Referee's order holding Liberty Northwest Insureance Corporation responsible for claimant's low back condition.

This responsiblity case was generated by the fact that claimant's employer was sold between the time that Farmer's Insurance accepted claimant's low back injury and August 1, 1986, when the low back condition became disabling. The initial claim had not been closed when claimant became disabled; therefore, this is not the classical aggravation/new injury dispute. Nevertheless, the question is whether claimant's occupational exposure while Liberty was on the risk independently contributed to claimant's disability such that Liberty is responsible for claimant's condition. Boise Cascade Corp. v. Starbuck, 296 Or 238 (1984).1/ The Referee found that claimant's work while Liberty was on the risk had independently contributed to his condition and accordingly set aside Liberty's denial. I agree.

Claimant suffered from low back pain which was associated with what claimant's treating physician, Dr. Buttler, chiropractor, described as a "repetitive trauma-induced" or "gradual onset" injury suffered while working as a truckdriver for Widing Transportation. An examining physician, Dr. Grossenbacher, M.D., diagnosed the condition as "mild degenerative disk disease with left sciatic nerve radiculopathy...related to his occupation as a truck driver." Claimant sought treatment but was able to continue working.

Widing then sold out to Arrow Transporation which was insured by Liberty. Claimant continued to perform the same tasks for Arrow as he had for Widing. Thereafter, claimant's pain increased so much that Dr. Buttler reported a "worsening of his condition" and authorized time loss. Dr. Buttler opined that claimant's post-sale work did contribute to an "exacerbation of his low back condition." There are no opinions to the contrary. Nevertheless, the majority would not impose responsibility on Liberty because claimant's post-July 21 symptoms were of like kind to those Farmers had already accepted.

Responsibility is "reassigned" to a subsequent employer when subsequent employment has independently contributed to a claimant's condition. The Supreme Court has used language suggesting that an independent contribution is shown when a claimant's later work contributes to an aggravation of his condition. Boise Cascade v. Starbuck, supra, 296 Or at 240. However, the Court of Appeals recently held that independent contribution cannot be shown by an increase in symptoms even if symptoms become disabling. Spurlock v. International Paper, 89 Or App 461 (February 10, 1988). Therefore, I conclude that if claimant's condition has worsened in part as a result of the later employment rather than as a result of the natural progression of the disease, then the later employer is responsible.

It is apparent to me that Dr. Buttler intended to say that claimant's condition was worse on August 1st than it had been on July 21 on account of his work for Arrow, and I would so find.

Insofar as the majority opinion may rely on an assumption that because claimant did not experience new symptoms--but only more severe symptoms--after July 21, to find that his condition did not worsen, I believe that reliance is misplaced. In this case, for all practical purposes, the symptoms were the injury. See, by analogy, Adsitt v. Clairmont Water District, 79 Or App 1, rev. den., 310 Or 338, 301 Or 666 (1986). Three doctors examined claimant. All believed the condition to be of gradual onset. All believed it to be work-related. None was able to identify a specific time when an injury occurred; indeed, none drew any distinction between claimant's work prior to the date the initial claim was made and claimant's work thereafter or between claimant's work when Farmers was on the risk and claimant's work when Liberty was on the risk. The specialist--Dr. Simpson, orthopedist--was not prepared to make a diagnosis although he agreed that the condition was work-related and agreed that it was real in that it produced limitation of ranges of motion and pain. Dr. Grossmacher, M.D., diagnosed a work-related degenerative disk disease. Dr. Buttler, chiropractor, diagnosed "lumbosacral sprain and myalgia." Since a clear diagnosis has not been achieved and no time of injury has been identified, it may be impossible for anyone, including the treating physician, to determine whether or not a condition has worsened except by inference from symptomology. There is nothing untoward about that. That is precisely what Dr. Buttler did, and I would not question it merely because no new symptoms were reported. It is clear from claimant's testimony and from his treating physician's reports, that claimant's pain and numbness had increased during the period of his employment by Arrow such that he became disabled. Under these circumstances, I would conclude that claimant's new work caused an increase in his disability such that Liberty is responsible.

[1] The affect of the pre-closure partial denial on claimant's entitlement to continued compensation is not discussed by the Referee (or by the Board majority). There was no need to address the issue because claimant withdrew his request for hearing after Liberty agreed to pay interim compensation to the date of the Opinion and Order without respect to the outcome of the responsibility debate. However, I observe that while the Board has approved preclosure responsibility denials in Jimmy C. Lay, 37 Van Natta 583 (1985) and Mason L. Asbury, 38 Van Natta 961 (1986), Farmer's, having accepted the claim, was not entitled to cease paying benefits pursuant to its responsibility denial until such time as it might be determined that Liberty was responsible. Retchless v. Laurelhurst Thriftway, 72 Or App 728, rev. den., 299 Or 251 (1985).

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

WCB 86-03841
March 21, 1988
Order on Reconsideration (Remanding)

Claimant requested reconsideration of our Order on Review dated October 13, 1987. We abated our order to allow sufficient time to consider the request. A response has been received from the insurer.

With his request for reconsideration, claimant submitted documents which show that after the hearing he underwent the surgery which we, in our Order on Review, found not to be reasonable and necessary. We treat the submission of these documents as a request for remand. Judy A. Britton, 37 Van Natta 1262 (1985). The documents were not available prior to the hearing and are highly probative on the issue of the reasonableness and necessity of claimant's surgery. After due consideration, we conclude that the case should be remanded to the Referee for admission of the documents and for further development on the surgery issue. Parmer v. Plaid Pantry #54, 76 Or App 405, 409 (1985).

IT IS SO ORDERED.

RONALD M. LYDAY, Claimant
Mark Malco, Claimant's Attorney
Davis, et al., Defense Attorneys

WCB 86-06814
March 21, 1988
Order on Review

Reviewed by Board Members Ferris and Johnson.

Claimant requests review of Referee Howell's order that dismissed his request for hearing as untimely. The issue is jurisdiction.

The Board affirms the order of the Referee with the following comment. In dismissing claimant's request for hearing, the Referee cited and relied upon the Board's decision is Leon E. Cowart, 38 Van Natta 916 (1986). That case was subsequently reversed by the Court of Appeals and remanded to the Board for reconsideration of whether the claimant had "good cause" for failing to timely file his request for hearing. Cowart v. SAIF, 86 Or App 748 (1987). On remand, the Board reconsidered the "good cause" issue and reaffirmed its previous decision. Leon E. Cowart, 40 Van Natta 22 (January 15, 1988). The present case is factually indistinguishable from Cowart. We affirm the Referee, therefore, but for the reasons stated in our most recent Cowart decision.

ORDER

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

JOHN L. ROUSSEAU, SR., Claimant
Brian Whitehead, Claimant's Attorney
SAIF Corp Legal, Defense Attorney
Garrett, et al., Defense Attorneys

WCB 86-15587 & 86-15588
March 21, 1988
Order Denying Request

Northwest Farm Bureau Insurance Company's counsel seeks Board authorization of a client-paid fee for services rendered in this matter, which eventually culminated in the parties' stipulated settlement and the Board's January 8, 1988 Order of Dismissal.

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

Inasmuch as the Board's January 8, 1988 order has neither been appealed, abated, stayed, nor republished, it has become final by operation of law. Accordingly, the Board lacks jurisdiction to consider counsel for Northwest Farm Bureau's request.

IT IS SO ORDERED.

ARLENE B. ALLEN-ADAMS, Claimant
Michael B. Dye, Claimant's Attorney
John Motley (SAIF), Defense Attorney

WCB 86-00799
March 24, 1988
Order on Review

Reviewed by Board Members Ferris and Crider.

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

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

Claimant, 40 at hearing, sustained a compensable low back strain in June 1985. She was off work for approximately four days and then returned to her regular job as a counter clerk. A Determination Order closed her claim in October 1985, with no award of permanent disability. On November 1, 1985, a Friday, she experienced increased low back pain, but was able to complete her work shift. Thereafter, she returned home via a carpool. During the carpool ride, she neither complained nor exhibited any pain behavior. Claimant did not return to work after November 1, 1985.

In January 1986, claimant was examined by a panel of physicians at the BBV Medical Services. The BBV physicians found no evidence of a worsened condition. Further, inasmuch as the BBV physicians questioned claimant's historical reliability, they were unable to state whether claimant's then current condition was causally related to her June 1985 injury.

In April 1986, Dr. Buza, claimant's family physician, reported that claimant's condition was solely attributable to an

unspecified "injury or disease." Buza's opinion was based upon his understanding that claimant had suffered no prior injuries.

In July 1986, claimant reported to Dr. Swoboda that any housework chores hurt her back. She further reported that she was unable to lift one-half gallon of milk. A few days later, surveillance films were taken of claimant. The films show claimant throwing and catching bundles of laundry, as well as bending at her waist.

In November 1986, Dr. Swoboda testified by way of deposition that claimant's condition in November 1985 was an aggravation of her June 1985 injury.

That same month, claimant was referred to Dr. Moore, M.D. Moore found that there was no organic explanation for claimant's physical complaints. Moore felt that claimant's continuing complaints were due to a hysterical conversion reaction.

In aggravation cases, the worker must prove: (1) a worsening of her condition that renders her more disabled (i.e., less able to work) than at the time of the last arrangement of compensation; and (2) a causal relationship between the worsened condition and the compensable injury. Smith v. SAIF, 302 Or 396 (1986); Stepp v. SAIF, 78 Or 438 (1986); ORS 656.273(1). Increased symptoms alone are not compensable, unless the worker suffers pain or additional disability that reduces her ability to work, thereby, resulting in a loss of earning capacity. Smith, 302 Or at 401.

Here, the BBV physicians questioned claimant's historical reliability and, therefore, refused to render an opinion concerning the etiology of claimant's allegedly worsened low back condition. Moore felt that claimant's complaints were not supported by any objective clinical findings, and opined that claimant's continuing complaints were due to a hysterical conversion reaction. Therefore, neither the BBV physicians nor Moore support a causal connection between claimant's allegedly worsened condition and her compensable June 1985 injury.

Buza's opinion is both confusing and conclusory. Buza opined that claimant's condition was due to "an injury or disease." However, it is unclear whether Buza was referring to the June 1985 injury, or claimant's alleged worsening on November 1, 1985. Finally, Swoboda conceded that it would be difficult to rely on his opinion, if claimant had not accurately reported her limitations. After reviewing the surveillance films, we find that claimant did not accurately report her degree of limitations to Swoboda. Accordingly, we are unpersuaded by the opinions of Buza and Swoboda. See Somers v. SAIF, 77 Or App 259 (1986).

We, therefore, agree with the Referee that claimant has failed to prove that her allegedly worsened low back condition is causally related to her compensable June 1985 injury.

ORDER

The Referee's order dated March 27, 1987, as supplemented herein, is affirmed.

LEONARD A. CHAMBERS, Claimant
Doblie & Associates, Claimant's Attorneys
Roberts, et al., Defense Attorneys

WCB 87-03511
March 24, 1988
Order on Review (Remanding)

Reviewed by Board Members Ferris and Crider.

Claimant requests review of Referee Daughtry's order that dismissed his request for hearing on the ground that the request was not timely filed. The issue is jurisdiction.

Claimant injured his neck in June 1974 when he slipped and bumped his head on a door casing. He was treated conservatively for a few weeks and then discontinued treatment. Claimant's claim for the injury was accepted, but has never been closed, apparently because of a clerical error. Claimant continued to experience periodic bouts of neck pain and in 1976 began treating about once every two weeks with Dr. Peltzer, a chiropractor. In 1981, he transferred his care to another chiropractor, Dr. Holman.

In June 1986, the insurer issued a denial which stated in pertinent part:

> "This will advise you that we are denying responsibility for your chiropractic treatment as the preponderance of medical evidence indicates that this is neither reasonable and necessary nor related to your original compensable condition."

Claimant was represented by an attorney at the time the denial was issued, but the insurer, as far as the record reflects, was not aware of that fact and did not send the attorney a copy of the denial. Claimant's attorney first became aware of the denial in March 1987 when claimant inquired whether the attorney had filed a request for hearing on the denial. Claimant's contact with his attorney apparently was prompted by a refusal of the insurer to pay medical bills submitted in late January 1987. The attorney immediately filed a request for hearing on the June 1986 denial. In April 1987, the insurer moved to dismiss the hearing request on timeliness grounds. A few days later, claimant's attorney filed a supplemental hearing request on what was characterized as the insurer's de facto denial of medical services in January 1987.

In his order, the Referee found that claimant had not filed his original request for hearing within 180 days and granted the insurer's motion. The Referee did not mention or expressly dispose of the supplemental hearing request filed in April 1987. We assume, however, that he intended his order to dispose of both the original and supplemental hearing requests.

On Board review, claimant concedes that the dismissal of his original request for hearing was proper. He argues, however, that the Referee erred in not finding that the supplemental request vested jurisdiction in the Hearings Division regarding medical services rendered after the insurer's June 12, 1986 denial.

We agree with claimant. The insurer's June 1986 denial was a denial of medical services, not a back-up denial of the

compensability of the accepted condition. The denial became final by operation of law. Under these circumstances, the res judicata effect of the denial is limited to medical services rendered on or before the date of the denial. See Patricia M. Dees, 35 Van Natta 120, 124 (1983); see also Karola Smith, 38 Van Natta 76, 77-78 (1986), aff'd mem., 83 Or App 275 (1987). The June 1986 denial has no collateral estoppel effect regarding the causal connection between the condition being treated and the compensable injury because that issue was never actually litigated. See Carr v. Allied Plating Co., 81 Or App 306, 309 (1986); Straube v. Larson, 73 Or App 501, 505, rev den 299 Or 683 (1985); F. James & G. Hazard, Civil Procedure § 11.17 at 565-66 (2d ed. 1977). To the extent, therefore, that claimant's supplemental hearing request concerned medical services rendered after June 12, 1986, it represented a separate cause of action which currently may be litigated.

This leaves the question of whether the supplemental hearing request, standing alone, satisfied the jurisdictional requirments of ORS 656.283 and 656.319. The supplemental request was in writing, was signed on behalf of claimant by his attorney, stated that a hearing was desired on the insurer's de facto denial of medical services and was mailed to the Board in timely fashion. The only requirement that the supplemental request did not satisfy was that the request include the address of the party requesting the hearing. See ORS 656.283(3). The request, however, did include the address of the claimant's attorney and a claim number, both of which the insurer could use to identify claimant and obtain his address. This information was sufficient for the orderly, efficient and fair operation of the worker's compensation system. We conclude, therefore, that strict compliance with the address requirement is not jurisdictional. See Burkholder v. SAIF, 11 Or App 334, 340-41 (1972); Thomas E. Harlow, 38 Van Natta 1406, 1411 (1986). The supplemental hearing request was sufficient to vest jurisdiction in the Hearings Division independent of the original hearing request. Accordingly, we reinstate claimant's supplemental hearing request and remand the case to the Referee for further development and a ruling on that request.

ORDER

The Referee's order dated May 13, 1987 is reversed in part. That portion of the order that dismissed claimant's supplemental request for hearing is reversed and the case is remanded to the Referee for further proceedings consistent with this order. The remainder of the Referee's order is affirmed.

PATRICK DUFFY, Claimant
Thomas O. Carter, Claimant's Attorney
Acker, Underwood, et al., Defense Attorneys

WCB 86-08009
March 24, 1988
Interim Order of Remand

The insurer requests review of that portion of Referee Mulder's order that: (1) found that the Hearings Division had jurisdiction to consider claimant's hearing request from the insurer's denial of his medical services claim for a right knee and back condition; and (2) set aside the insurer's denial of that claim. On review, the issues are jurisdiction and compensability.

We note that the Referee admitted a number of exhibits into evidence which are not present in the record. These exhibits

include: a Form 801, a medical report and a denial letter, all relating to Claim No. C604-24168, identified as Exhibits 1 through 3 on the master index of exhibits submitted by the insurer; a Form 801, various chart notes and medical reports, and a Determination Order, all relating to Claim No. C604-29060, identified as Exhibits 1 through 5 on the master index of exhibits; and a Form 801, and various chart notes, medical reports and letters, all relating to Claim No. C604-29260, identified as Exhibits 1 through 9 on the master index of exhibits.

Pursuant to ORS 656.295(5), we may remand to the Referee for further evidence taking, correction or other necessary action when we determine that a case has been improperly, incompletely or otherwise insufficiently developed. We conclude that the omission of the exhibits described above constitutes an improper, incomplete, or otherwise insufficient development of this case.

Accordingly, we remand to the Referee to reconsider this matter in light of our discovery. Should the Referee conclude that a hearing is necessary to identify the aforementioned exhibit and include it in the record, he is directed to initiate the appropriate proceedings. The Referee is further directed to issue an order on remand indicating the effect, if any, the inclusion of these exhibits has upon his original order.

ORDER

This case is remanded to the Referee for further action consistent with this order.

JOYCE A. ELLIS, Claimant
Minturn, et al., Claimant's Attorneys
Beers, et al., Defense Attorneys

WCB 86-07849
March 24, 1988
Order of Dismissal

Claimant has requested Board review of those portions of Referee Gruber's order that: (1) declined to grant permanent total disability and scheduled permanent disability, but increased claimant's unscheduled permanent disability award for a left shoulder injury from 30 percent (96 degrees), as awarded by a Determination Order, to 65 percent (208 degrees); (2) found that the claim had been properly closed; and (3) upheld the insurer's denial of her aggravation claim for her left ankle and psychological condition.

The parties have submitted for our approval a proposed "Disputed Claim Settlement." In lieu of the Referee's order, the agreement is designed to resolve all issues raised or raisable in this matter, as well as the issues pending before the Hearings Division in WCB Case No. 87-17584. That portion of the settlement which pertains to the Hearings Division has received Referee approval.

Pursuant to the stipulation, claimant agrees to withdraw her hearing request and, implicitly, her request for Board review. We have approved the parties' agreement, thereby fully and finally resolving this matter. Accordingly, the request for Board review is dismissed.

IT IS SO ORDERED.

Board Member Crider, dissenting:

The dismissal of the pending request for hearing is

inappropriate because the underlying Disputed Claim Settlement is invalid under ORS 656.236(1) and should not have been approved.

Claimant was injured in July, 1983. The insurer accepted the claim. Several years later, claimant was examined by various psychiatrists all of whom diagnosed psychiatric conditions and attributed them to the injury. The claim was closed with an award of 30 percent unscheduled permanent partial disability. Claimant filed an aggravation claim contending that her condition had worsened since the Determination Order. The insurer denied the claim. The claimant requested hearing on the denial and also challenged the Determination Order. The aggravation denial was upheld on the ground that claimant's condition had not worsened since the Determination Order and the award was increased to 65 percent by opinion and order. A request for review of that order was made to the Board.

While that request was pending, the parties entered into a Disputed Claim Settlement. In the settlement document, the insurer contends that: (1) an intervening noncompensable injury has "forever caused the alleged July 2, 1983 injury to be rendered nonmaterial to claimant's condition"; (2) "the original acceptance of the claim was procured by misrepresentation"; and (3) "claimant suffers from a noncompensable psychgenic condition which is the sole cause of the entirety of claimant's symptoms from the inception of the claim and continuing to date". The claimant, while denying these contentions, agreed to forgo all future benefits related not only to the denied aggravation claim but also to the original accepted claim in return for a lump sum payment. The settlement is unlawful.

First, assuming there is any evidence to support the contention that an intervening injury may be responsible for claimant's current symptomatology, an intervening injury does not render valid a release of all future rights related to an accepted claim. EBI v. Freschette, 71 Or App 526 (1984). Second, there is no support in the record for the contention that claimant misrepresented anything or that such misrepresentation led the insurer to accept her claim five years ago. Therefore, there is no bona fide dispute with respect to the factual predicate for a lawful backup denial of the compensability of the original accepted claim; and there being no bona fide dispute on the misrepresentation issue, there can be no legitimate dispute as to the propriety of a backup denial. See Richmond v. SAIF, 85 Or App 444 (1987). Third, there is absolutely no support in the record for the insurer's contention that claimant never suffered an injury and that, rather, all of her symptoms derive from a preexisting psychological disorder. Indeed, there is no evidence that the injury did not occur and there is no evidence that her psychological problems are not secondary to the accepted injury. Thus, even if there were a bona fide dispute with respect to the validity of the issuance of a backup denial, there would be no bona fide dispute over the underlying compensability issue. Richmond v. SAIF, supra. There being no dispute, the settlement was invalid and should not have been approved by the Board.

HUBERT E. EVANS, Claimant
Rex Q. Smith, Claimant's Attorney
Nelson, et al., Defense Attorneys

WCB 87-00647
March 24, 1988
Order Denying Reconsideration

Claimant has requested reconsideration of the Board's Order on Review dated March 2, 1988. He requests that the Board award his attorney an insurer-paid attorney fee for services rendered at the hearing in addition to the $200 fee assessed under ORS 656.382(1) on the penalty issue. The fee assessed in connection with the penalty issue was reasonable in light of the factors enumerated in OAR 438-15-010(6). An additional fee cannot be awarded under ORS 656.382(2) because the insurer did not request or cross-request a hearing on any issue. An additional fee cannot be assessed under 656.386(1) because claimant did not prevail finally on a denied claim. Claimant's request for reconsideration, therefore, is denied. Appeal rights shall continue to run from the date of our prior order.

IT IS SO ORDERED.

SHERMAN V. GRIFFITH, Claimant
Tharp & Van Atta, Claimant's Attorneys
Davis, Bostwick, et al., Defense Attorneys
Schwabe, et al., Defense Attorneys

WCB 85-11244, 85-05496 & 85-08267
March 24, 1988
Interim Order of Remand

Claimant has requested Board review of Referee Fink's January 13, 1987 order that upheld denials of his occupational disease claim for a lung condition issued by Cigna Insurance Co. and Argonaut Insurance. The hearing concerning this matter was convened on November 6, 1986 in Ontario, Oregon. It was reported.

Following claimant's request for review, a transcription of the proceedings was requested. See ORS 656.295(3). However, the reporter who reported the hearings has refused to comply with his contractual obligation to provide a transcript. The Board is persuaded that a hearing transcript is presently unobtainable.

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

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

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

IT IS SO ORDERED.

RICHARD R. INGALLS, Claimant
Pozzi, et al., Claimant's Attorneys
SAIF Corp Legal, Defense Attorney

WCB 86-03202
March 24, 1988
Second Interim Order of Remand

Claimant and the SAIF Corporation have requested reconsideration of our November 20, 1987 interim order that remanded this matter to the Referee with instructions to reconvene a hearing. Our action was prompted by the hearing reporter's failure to provide a transcript of the parties' previous hearing.

Contending that a new hearing would be impractical, unfair, and potentially prejudicial to their respective positions, the parties object to our interim order. Instead, they suggest that we take further actions designed to recover the hearing transcript. These suggested actions would include initiating mandamus or contempt proceedings against the reporter.

To allow us sufficient time to consider the parties' request and to renew our attempts to secure a hearing transcript, we abated our order. After further consideration of this matter, including another series of unsuccessful attempts to obtain a hearing transcript, we render the following decision.

Each of the parties' suggestions have been thoroughly reviewed and considered. Unfortunately, under these circumstances, we do not find them to be practical alternatives. To begin, the reporter was an independent contractor who agreed to provide hearing transcripts for a fee. Thus, an adequate remedy to recover the requested transcript would rest in a civil cause of action for breach of contract. Inasmuch as such a remedy could be achieved just as efficiently in the ordinary course of the law as it could through mandamus proceedings, we do not consider a writ of mandamus to be a suitable option.

Furthermore, contempt procedures for such conduct is certainly available against reporters who fail to timely provide transcripts of court proceedings. See ORS 8.310; 19.029; 19.078; 33.010; 138.185. Yet, we have neither been cited to, nor have we found, any authority that would empower us to initiate similar proceedings in this forum.
Consequently, in the interests of substantial justice, we continue to conclude that the most appropriate action to be taken is to remand this case for a new hearing.

Accordingly, the parties' requests for reconsideration are granted and our prior Interim Order of Remand withdrawn. On reconsideration, as supplemented herein, we fully adhere to and republish our former order, effective this date.

IT IS SO ORDERED.

LUTHER R. McLAIN, Claimant
SAIF Corp Legal, Defense Attorney

Own Motion 88-0088M
March 24, 1988
Own Motion Order

The SAIF Corporation has submitted to the Board claimant's claim for a worsening of his December 26, 1974 compensable right foot injury. Claimant's aggravation rights have expired. SAIF recommends that the claim be reopened for payment of temporary total disability compensation beginning March 7, 1988, the date of claimant's surgery. Claimant contends that his compensation should begin effective March 3, 1988, the date that

his treating surgeon recommended that he stop working in order to prepare his foot for the March 7, 1988 surgery.

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

Following our review of this record, we are persuaded that claimant's compensable injury has worsened requiring inpatient surgery and other treatment requiring hospitalization. See ORS 656.278(1)(a). Accordingly, claimant's claim is reopened with temporary total disability compensation to commence March 7, 1988, the date of his surgery, and to continue until he returns to his regular work at his regular wage or is medically stationary, whichever is earlier. See OAR 438-12-052(2). Reimbursement from the Reopened Claims Reserve is authorized to the extent allowed under ORS 656.625 and OAR 436, Division 45. When appropriate, the claim shall be closed by the employer pursuant to OAR 438-12-055.

IT IS SO ORDERED.

BILLIE I. RUMPEL, Claimant
Yturri, Rose, et al., Claimant's Attorneys
Rick Barber (SAIF), Defense Attorney

WCB 85-01331
March 24, 1988
Interim Order of Remand

The SAIF Corporation has requested Board review of Referee Knapp's November 12, 1986 order that: (1) set aside its partial denial of claimant's current left leg and ankle condition; (2) directed it to pay for claimant's physical therapy and nerve conduction studies; and (3) assessed penalties and associated attorney fees for an unreasonable failure to pay for the therapy and studies. The hearing concerning this matter was convened on July 23, 1986. It was reported.

Following SAIF's request for review, a transcription of the proceedings was requested. See ORS 656.295(3). However, the reporter who reported the hearings has refused to comply with his statutory and contractual obligation to provide a transcript. The Board is persuaded that a hearing transcript is presently unobtainable. Furthermore, the parties are unable to reach an agreement concerning the testimony given at the hearings.

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

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

We retain jurisdiction over this matter. Upon

completion of the hearing, Referee Knapp shall obtain and certify a copy of the transcript of the hearing to the Board. The transcript should be provided to the Board within 30 days of the hearing. In addition, Referee Knapp shall provide an interim order on remand, discussing the effect, if any, the additional evidence has had upon his prior order. Once the Board receives the transcript, copies will be provided to the parties and a briefing schedule will be implemented.

IT IS SO ORDERED.

RANDY B. WALKER, Claimant
Steven C. Yates, Claimant's Attorney
Beers, Zimmerman & Rice, Defense Attorneys

WCB 86-02306
March 24, 1988
Order on Review

Reviewed by Board Members Ferris and Crider.

The insurer requests review of those portions of Referee Leahy's order which: (1) increased claimant's unscheduled permanent disability award for a low back injury from 5 percent (16 degrees), as awarded by Determination Order, to 25 percent (80 degrees); and (2) set aside its partial denial of claimant's medical services claim for low back surgery. Claimant cross-requests review of that portion of the order which directed that payment of one-half of claimant's attorney fee, awarded on the medical services issue, be made contingent on the actual performance of surgery. The issues are extent of unscheduled disability, medical services, and attorney fees.

We reverse that portion of the Referee's order which set aside the insurer's denial of low back surgery, and we modify that portion of the order which increased claimant's unscheduled disability award.

Claimant, a 29-year-old sawmill trimmer, compensably injured his low back in June 1985. His injury was initially diagnosed as acute traumatic severe lumbosacral sprain with myalgia and myofascitis and associated intervertebral disc derangement. He was taken off work. During the next five months, he treated conservatively with Drs. Buttler and McMahon, chiropractic and naturopathic physicians. Claimant attempted to return to modified work in July and August 1985, but was unsuccessful due to symptomatic flare-ups. He terminated his employment shortly thereafter.

A CT scan on September 16, 1985 revealed disc protrusions at L4-5 and L5-S1 with mild facet joint hypertrophy, but the clinical significance of the protrusions was described as "uncertain." On October 18, 1985, claimant was examined by a panel of physicians at the Orthopaedic Consultants. They diagnosed lumbar strain, by history, and greater trochanteric bursitis on the right.

In November 1985, claimant experienced increasing back pain and was fitted with a "TENS" unit. On November 14, 1985, claimant was examined by Dr. Hazel, an orthopedist, who initially diagnosed degenerative disc disease with right sciatica and scheduled a CT scan that day. The scan revealed bulging of the annulus at L4-5 and bulging or herniation of disc material at L5-S1 with possible compression of the right nerve root. Thereafter, Dr. Hazel assumed primary care of claimant's condition, placing him on a regimen of exercise.

On December 6, 1985, Dr. Hazel requested authorization for surgery. However, a subsequent myelogram yielded essentially normal results, apparently prompting Dr. Hazel to recommend against surgery. He later explained that, while claimant has a classic history for disc disease, he lacked localized findings that could be remedied by surgery. He recommended, instead, that future treatment include a hardening program to increase stamina and endurance. On March 18, 1986, Dr. Hazel declared claimant medically stationary with no objective residuals and noted that his leg pain would diminish with time.

On May 19, 1986, claimant was examined by Dr. Smith, a neurologist, who referred him for an MRI scan. According to the evaluating physician, the scan "suggest[ed] a disc herniation rather than excessive posterior bulging of the annulus alone but this differentiation is not made with certainty." Based on the MRI results, Dr. Smith diagnosed lumbar spondylosis stenosis with discal prolapse at L5-S1, associated with lateral recess and foraminal stenosis. He recommended surgical exploration at L4-5 and L5-S1 for a confirmed herniated lumbar disc, with interlaminar decompression and probable discectomy. The insurer received this report on June 12, 1986. A day earlier, on June 11, 1986, the claim was closed by Determination Order with an award of 5 percent unscheduled permanent disability.

On July 17, 1986, claimant saw Dr. Hazel, who maintained that claimant had no neurological deprivation or motion anomalies. He estimated a 50 to 65 percent chance of significant improvement from surgery and concluded that claimant was a poor candidate for surgery on clinical and statistical bases.

Dr. Smith did not concur with Hazel's report. He noted that claimant had a definite anatomical abnormality and that surgery would be more expeditious and certain than any other method of treatment. He requested authorization for surgery.

On October 21, 1986, claimant was examined by a panel of physicians at Western Medical Consultants. They reviewed the MRI results and diagnosed lumbosacral strain, by history, and greater trochanteric bursitis on the right, disagreeing with Dr. Hazel's diagnosis of degenerative disc disease. They agreed, however, that work hardening would be appropriate, and recommended against surgery. Dr. Smith did not concur with their report and again requested authorization for surgery.

On November 5, 1986, the insurer denied Dr. Smith's request for surgery. Later in November, Dr. Smith wrote the insurer that he had not completed a Form 829 (Change of Attending Physician) because he did not consider himself claimant's treating physician and would not do so until surgery was authorized. He added that he had not corresponded with either claimant or his attorney since the June 1986 examination. Sometime in late 1986, Smith referred claimant to Dr. Keizer, an orthopedist, for a second opinion concerning surgery. Dr. Keizer recommended against surgery.

Claimant currently experiences a heat sensation and slight pressure in his right hip. He is limited in prolonged walking or sitting. He feels a pinch in his low back whenever he bends or twists. He stated that he can only lift about 75 pounds

occasionally. When asked at hearing whether he wished to undergo surgery, claimant responded that he would like to "hold off on the surgery for now," but that he would like to keep it as a future option.

Claimant has an eleventh grade education. His work history consists primarily of building pole barns, sawmill labor, and "odds and end" jobs including truck driving for his parents. After the injury, he worked framing houses for a month but was unable to continue due to his limitations.

The Referee increased claimant's unscheduled award from 5 percent to 25 percent, based on his "mild" physical impairment and other social and vocational factors. The Referee also set aside the insurer's denial of back surgery, relying on Dr. Smith's "convincing reasons for surgery." Claimant's attorney was awarded a $1,200 attorney fee for services at hearing concerning the surgery issue, to be paid by the insurer "when and if" claimant submits to surgery. By Supplemental Opinion and Order, the Referee modified the attorney fee award to make $600 payable immediately, with payment of the remaining $600 contingent on the actual performance of surgery.

For his compensable injury, claimant is entitled to medical services "for such period as the nature of the injury or the process of the recovery requires." ORS 656.245(1). Claimant's medical expenses are compensable so long as they are reasonably and necessarily incurred in the treatment of his injury. West v. SAIF, 74 Or App 317, 320 (1985); McGarry v. SAIF, 24 Or App 883, 888 (1976). Claimant bears the burden of proving that the treatment is reasonable and necessary. James v. Kemper Ins. Co., 81 Or App 80, 81 (1986).

Dr. Hazel, who was claimant's treating orthopedist from November 1985 through at least March 1986, found no clinical or statistical basis for surgery. He explained that there were no localized findings that could be remedied by surgery and that claimant would have, at best, a 65 percent chance of significant improvement from surgery. On the other hand, Dr. Smith, the consulting neurosurgeon, recommended surgery based on his diagnosis of a herniated lumbar disc.

We find Dr. Hazel's opinion most persuasive. As treating physician, he had the best opportunity to evaluate claimant's treatment, progress and needs over the course of several months. Moreover, we conclude that he was in the superior position to determine whether surgery was warranted, rather than Dr. Smith, who examined claimant only once.

Further, Dr. Hazel's opinion was better reasoned than that of Dr. Smith. Dr. Hazel recommended against surgery in the absence of any localized findings. Although Dr. Smith diagnosed a herniated disc, that diagnosis was unpersuasive because it was based on inconclusive MRI scan results which, at most, "suggested" a herniation rather than bulging. The Orthopaedic Consultants reviewed the same scan results and found no herniation.

Finally, we were also persuaded by claimant's own testimony that he would like to "hold off on the surgery for now." Claimant's reluctance to undergo surgery further weighs

against a finding that it is reasonable and necessary to the recovery process of his industrial injury.

Our disposition of the medical services issue moots the attorney fee issue raised in claimant's cross-request for review. We note, however, that there is no authority for "contingency" attorney fee awards.

In rating the extent of claimant's unscheduled permanent disability, we consider medical and lay evidence of his physical impairment from the compensable injury and all 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, including claimant's testimony concerning his low back pain, we find that his disabling pain represents a mild impairment. His education, adaptability to less strenuous labor, and labor market potential further impacted his earning capacity, though the impact is mitigated somewhat by his age. Consequently, after due consideration of the aforementioned guidelines, we conclude that 10 percent (32 degrees) unscheduled disability adequately compensates claimant for his low back injury.

ORDER

The Referee's order dated February 9, 1987, as supplemented on February 25, 1987, and March 5, 1987, is modified in part and reversed in part. In lieu of the Referee's award, and in addition to the Determination Order's award of 5 percent (16 degrees) unscheduled permanent disability, claimant is awarded 5 percent (16 degrees) unscheduled permanent disability for a low back injury, giving him a total unscheduled award of 10 percent (32 degrees). Claimant's attorney fee for the increased compensation shall be adjusted accordingly. That portion of the order which set aside the insurer's partial denial of claimant's medical services claim for low back surgery is reversed. The denial is reinstated and upheld. Claimant's attorney fee for prevailing over the denial is disallowed.

GAYLE L. FITZGERALD, Claimant
Malagon & Moore, Claimant's Attorneys
SAIF Corp Legal, Defense Attorney

Own Motion 87-0471M
March 28, 1988
Own Motion Determination

The Board issued its Own Motion Order in this case on September 15, 1987, reopening claimant's November 4, 1980 right shoulder injury claim.

The claim has now been submitted for closure. Claimant is granted temporary total disability from August 14, 1987 through February 29, 1988, less time worked. Inasmuch as this case had been reopened prior to the effective date of the amendment to ORS 656.278(1), we also have authority to consider the extent of claimant's permanent disability.

Following our review of the record, we conclude that claimant is entitled to an award of unscheduled permanent dis-

ability for the right shoulder in addition to the 10 percent (32 degrees) she has previously received. Accordingly, claimant is granted an additional award of 15 percent (48 degrees) unscheduled permanent disability. As a reasonable attorney's fee, claimant's attorney is awarded 25 percent of this increased award, not to exceed $600. The SAIF Corporation may offset any overpaid temporary disability compensation created by this determination against claimant's permanent disability award. However, claimant's attorney fee is not subject to any offset. See OAR 438-15-085(2).

IT IS SO ORDERED.

DOUGLAS N. GIBSON, Claimant
SAIF Corp Legal, Defense Attorney

Own Motion 87-0550M
March 28, 1988
Own Motion Order

Claimant has requested that the Board exercise its own motion authority and reopen his claim for an alleged worsening of his November 9, 1981 compensable low back injury. Claimant's aggravation rights have expired. Stating that it continues to pay for claimant's medical benefits, the SAIF Corporation opposes reopening of this claim for the payment of temporary total disability compensation.

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

Here, claimant has neither been hospitalized nor undergone surgery. Accordingly, we are without authority to grant the request for own motion relief.

IT IS SO ORDERED.

SANFORD E. COLLINS, Claimant
Michael B. Dye, Claimant's Attorney
Davis & Bostwick, Defense Attorneys

WCB 87-06676
March 31, 1988
Order of Remand

Claimant requested Board review of Referee Daron's order that declined to award unscheduled permanent disability for a neck and upper back injury in addition to the 20 percent (64 degrees) claimant had previously received. The parties have advised the Board that they have resolved the issues raised herein, as well as the issues presently pending before Referee Borchers in WCB Case No. 87-19188. The parties are currently preparing a written agreement to memorialize the settlement of these issues. To facilitate the resolution process for both cases, the parties request that this matter be remanded to Referee Borchers for consolidation with WCB Case No. 87-19188.

After review of this matter, we conclude that remand is appropriate. Accordingly, this case is remanded to Referee Borcher for consideration and approval of the parties' settlement agreement. The Referee's review will be in conjunction with her review of those portions of the agreement which pertain to the issues raised in WCB Case No. 87-19188.

IT IS SO ORDERED.

WILLIAM G. STORY, Claimant
Malagon & Moore, Claimant's Attorneys
Foss, et al., Defense Attorneys

WCB 87-18257
March 31, 1988
Order of Dismissal (Remanding)

The self-insured employer has requested Board review of Referee McCullough's March 8, 1988 order. The request was received on March 15, 1988. That same day, Referee McCullough abated his order to consider claimant's request for reconsideration.

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

Since the Referee abated his order simultaneously with the employer's request for Board review, we shall give effect to the abatement. Accordingly, the request for Board review is dismissed as premature. This matter is remanded to the Referee for further action.

IT IS SO ORDERED.

ORDERS OF ABATEMENT

ROBERT L. AKERSON, Claimant
Malagon & Moore, Claimant's Attorneys
Roberts, et al., Defense Attorneys

WCB 85-14555 & 85-11545
February 5, 1988
Order of Abatement

Reviewed by Board Members Crider and Ferris.

The insurer has requested reconsideration of the Board's Order on Review dated January 12, 1988. In order to allow sufficient time to consider the request, the Board withdraws and abates its Order on Review, effective this date. Claimant's attorney is allowed 14 days from the date of this order in which to respond.

IT IS SO ORDERED.

EARL M. BROWN, Claimant
Malagon & Moore, Claimant's Attorneys
Roberts, et al., Defense Attorneys

WCB 86-00251
February 5, 1988
Order of Abatement

The insurer has requested reconsideration of the Board's Order on Review dated January 12, 1988. In order to allow sufficient time to consider the request, the Board withdraws and abates its Order on Review, effective this date. Claimant's attorney is allowed 14 days from the date of this order in which to respond.

IT IS SO ORDERED.

CAROL DAVIS, Claimant
Vick & Gutzler, Claimant's Attorneys
Dennis Martin (SAIF), Defense Attorney
Garrett, et al., Defense Attorneys

WCB 85-00169 & 86-10997
February 12, 1988
Order of Abatement

The SAIF Corporation has requested reconsideration of our Order on Review dated January 27, 1988. In order to allow time for Northwest Farm Bureau and claimant to respond and for the Board to consider the request, our Order on Review is abated and withdrawn, effective this date. Farm Bureau and claimant are allowed 14 days from the date of this order in which to file their responses. Thereafter, this matter shall be taken under advisement.

IT IS SO ORDERED.

CAROL DAVIS, Claimant
Vick & Gutzler, Claimant's Attorneys
Dennis Martin (SAIF), Defense Attorney
Garrett, et al., Defense Attorneys

WCB 85-00169 & 86-10997
March 2, 1988
Amended Order of Abatement

Northwest Farm Bureau has requested reconsideration of our Order on Review dated January 27, 1988. On February 12, 1988, we previously abated our order pursuant to the SAIF Corporation's request for reconsideration. In order to allow time for the Board to consider both requests, the parties are granted the following time periods in which to respond: (1) Farm Bureau and claimant are allowed 14 days from the date of this order in which to file their respective responses to SAIF's request for reconsideration; and (2) SAIF and claimant are allowed 14 days from the date of this order in which to file their respective responses to Farm Bureau's request for reconsideration. Thereafter, this matter shall be taken under further advisement.

IT IS SO ORDERED.

TERRY L. LINK, Claimant
Malagon & Moore, Claimant's Attorneys
Roberts, et al., Defense Attorneys

WCB 86-01751
February 5, 1988
Order of Abatement

The insurer has requested reconsideration of the Board's Order on Review dated January 12, 1988. In order to allow sufficient time to consider the request, the Board withdraws and abates its Order on Review, effective this date. Claimant's attorney is allowed 14 days from the date of this order in which to respond.

IT IS SO ORDERED.

The Beneficiaries of
ROCKNE LUCKMAN (Deceased), Claimant
Martin McKeown, Claimant's Attorney
Kate Donnelly (SAIF), Defense Attorney

WCB 85-12369 & 86-04809
March 16, 1988
Order of Abatement

The SAIF Corporation has requested reconsideration of our Order on Review dated February 25, 1988. In order to allow time to consider SAIF's request, as well as claimant's response, our Order on Review is abated and withdrawn, effective this date. Following our further consideration of this matter, the parties will be advised of our decision.

IT IS SO ORDERED.

BARBARA D. OLINGHOUSE, Claimant
Malagon & Moore, Claimant's Attorneys
Roberts, et al., Defense Attorneys

WCB 86-01750
February 5, 1988
Order of Abatement

The insurer has requested reconsideration of the Board's Order on Review dated January 12, 1988. In order to allow sufficient time to consider the request, the Board withdraws and abates its Order on Review, effective this date. Claimant's attorney is allowed 14 days from the date of this order in which to respond.

IT IS SO ORDERED.

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BEFORE THE DIRECTOR OF THE
DEPARTMENT OF INSURANCE AND FINANCE
OF THE STATE OF OREGON

In the Matter of the Amendment of OAR Chapter 436, Department of Insurance and Finance, Division 10, Medical Services.	ORDER OF ADOPTION

The Director of the Department of Insurance and Finance, pursuant to the rulemaking authority in ORS 656.726(3); and in accordance with the procedure provided by ORS 183.335, amends OAR Chapter 436, Department of Insurance and Finance, Division 10, Medical Services.

On November 20, 1987, the Department of Insurance and Finance filed Notice of Public Hearing with the Secretary of State to provide for accurate filing of medical services and reporting and ensure quality of medical care. The Statement of Need and Statutory Authority and the Statement of Fiscal Impact were also filed with the Secretary of State.

Copies of the notice were mailed to interested persons in accordance with OAR 436-01-000 and to those on the Department's distribution mailing list as their interest indicated. The notice was published in the December 1, 1987, Secretary of State's Bulletin.

On December 21, 1987, the public hearing was held as announced. A summary of the written testimony and agency responses thereto is contained in Exhibit "C." This summary is on file and available for public inspection between the hours of 8 a.m. and 5 p.m., normal working days Monday through Friday in the Administrator's Office, Workers' Compensation Division, Labor and Industries Building, Salem, OR 97310.

Having reviewed and considered the record of public hearing; and being fully advised, I make the following findings under the authority granted by ORS 656.726(3):

(1) The applicable statutes have been followed;

(2) The applicable rulemaking procedures have been followed and are within the Director's authority; and

(3) After reviewing and considering data, views and arguments presented at the public hearing and in written testimony, the rules being adopted are reasonable and proper.

IT IS THEREFORE ORDERED:

(1) OAR Chapter 436, Division 10, Medical Service as set forth in Exhibit "A" attached hereto, certified a true copy and hereby made a part of this order, is adopted this date, to be effective February 1, 1988.

(2) A certified true copy of the Order of Adoption and these rules, with Exhibit "B" consisting of the Citation of Statutory Authority, Statement of Need, Documents Relied On, and Fiscal Impact Statement, attached hereto and hereby made a part of this order be filed with the Secretary of State.

(3) A copy of the Rules and attached Exhibit "B" be filed with the Legislative Counsel, pursuant to the provisions of ORS 183.715 within 10 days after filing with the Secretary of State.

DATED THIS 20th DAY OF January 1988.

DEPARTMENT OF INSURANCE AND FINANCE

/s/ Theodore R. Kulongoski

Theodore R. Kulongoski, Director

EXHIBIT "A"

OAR 436

DIVISION 10

MEDICAL SERVICE

Applicability of Rules

436-10-003 (1) These rules are effective to carry out the provisions of ORS 656.245, 656.248, 656.252, 656.254, 656.325, and 656.794.

(2) The provisions of OAR 463-10-090 shall be applicable to all services rendered subsequent to the effective date of these rules.

Hist: Filed 6/5/78 as Admin. Order 7-1978, eff. 6/5/78
Amended 1/28/80 as Admin. Order 2-1980, eff. 2/1/80
Amended 2/23/82 as Admin. Order 5-1982, eff. 3/1/82
Amended 1/16/84 as Admin. Order 1-1984, eff. 1/16/84
Amended 4/29/85 as Admin. Order 2-1985, eff. 6/3/85;
Renumbered from OAR 436-69-004, 5/1/85
Amended 12/10/85, as Admin. Order 6-1985, eff. 1/1/86
Amended 1/20/88 as Admin. Order 1-1988, eff. 2/1/88

Definitions

436-10-005 Unless the context otherwise requires:

(1) "Attending Physician" means a doctor or physician who is primarily responsible for the treatment of a worker's compensable injury or illness.

(2) "Board" means the Workers' Compensation Board of the Department of Insurance and Finance.

(3) "Claim" means a written request for compensation from a worker or worker's agent, or any compensable injury or illness of which an employer has notice or knowledge.

(4) "Claimant" means the worker making a claim.

(5) "Consulting Physician" means a licensed physician who examines a worker, or the worker's medical record, at the request of the attending physician to aid in diagnosis and/or treatment, and who may, at the request of the attending physician, provide specialized treatment of the compensable injury or illness.

(6) "Current Procedural Terminology" means the Current Procedural Terminology, fourth edition, 1985, published by the American Medical Association.

(7) "Customary Fee" means a fee that falls within the range of fees normally charged for a given service.

(8) "Department" means the Oregon Department of Insurance and Finance, consisting of the Board, the Director and all their assistants and employes.

(9) "Direct control and supervision" means the physician is on the same premises, at the same time, as the person providing a medical service ordered

by the physician. The physician can modify, terminate, extend or take over the medical service at any time.

A medical service provided at a site removed from the physician, or provided when the physician is not present on the premises, is not under the direct control and supervision of the physician.

(10) "Director" is the Director of the Department of Insurance and Finance.

(11) "Disability Prevention Services" means services provided to an injured worker to prevent the injury from causing continuing disability. Such services include physical restoration and psychologic, psychiatric, and vocational evaluation and counseling.

(12) "Elective Surgery" means surgery which may be required in the process of recovery from an injury or illness but need not be done as an emergency to preserve life, function, or health. Pain, of itself, does not constitute a surgical emergency.

(13) "Hearings Division" means the Hearings Division of the Workers' Compensation Board.

(14) "Insurer" means the State Accident Insurance Fund Corporation, a guaranty contract carrier, or a self-insured employer.

(15) "Major Orthopedic or Neurologic Surgery" means operations on the spine, shoulder, elbow, hip, knee or ankle joints; replacement of any joint; surgery for thoracic outlet syndrome. Surgery for carpal tunnel syndrome is not major neurologic surgery.

(16) "Medical Director" means the physician in the office of the director of the Department of Insurance and Finance.

(17) "Medical Service" means any medical, surgical, chiropractic, dental, hospital, nursing, ambulance, or other related services; also any drugs, medicines, crutch, prosthesis, brace, support or physical restorative device.

(18) "Medically Stationary" means that no further material improvement would reasonably be expected from medical treatment or the passage of time.

(19) "Peer Review" means the evaluation of the care provided to a worker by review of the pertinent records and/or personal interview with the attending physician or consultant. Such review may be conducted by a committee of the provider's peers and/or any other appropriate body selected by the director.

(20) "Physical Capacity Evaluation" means an objective, directly observed, measurement of worker's ability to perform a variety of physical tasks combined with statements of abilities by worker and evaluator. Physical tolerance screening, Blankenship's Functional Evaluation, Functional Capacity Assessment, and Work Tolerance Screening shall be considered to have the same meaning as Physical Capacity Evaluation.

(21) "Physician" or "Doctor" means a person duly licensed to practice one or more of the healing arts in this state within the limits of the license of the licentiate.

(22) "Promptly" means without delay.

(23) "Report" means transmittal of medical information in a narrative letter, on a form or in progress notes from the worker's medical file. Reports may be handwritten but all shall be legible and include all relevant or requested information.

(24) "Treating Physician" means attending physician.

(25) "Usual Fee" means the fee charged the general public for a given service.

(26) "Work Capacity Evaluation" means a physical capacity evaluation with special emphasis on the ability to perform a variety of vocationally oriented tasks based on specific job demands. Work Tolerance Screening shall be considered to have the same meaning as Work Capacity Evaluation.

(27) "Worker" means a subject worker as defined in ORS 656.005.

(28) "Work Hardening" means an individualized, medically ordered and monitored, work oriented treatment process. Involves the worker in simulated or actual work tasks that are structured and graded to progressively increase physical tolerances, stamina, endurance and productivity to return to work goals.

Hist: Filed 10/20/76 as Admin. Order 4-1976, eff. 11/1/76
Amended 6/5/78 as Admin. Order 7-1978, eff. 6/5/78
Amended 1/28/80 as Admin. Order 2-1980, eff. 2/1/80
Amended 2/23/82 as Admin. Order 5-1982, eff. 3/1/82
Amended 1/16/84 as Admin. Order 1-1984, eff. 1/16/84
Amended 4/29/85 as Admin. Order 2-1985, eff. 6/3/85;
Renumbered from OAR 436-69-005, 5/1/85
Amended 12/10/85 as Admin. Order 6-1985, eff. 1/1/86
Amended 6/26/86 as Admin. Order 4-1986, eff. 7/1/86
Amended 2/20/87 as Admin. Order 2-1987, eff. 3/16/87
Amended 1/20/88 as Admin. Order 1-1988, eff. 2/1/88

Reporting

436-10-030 (1) The act of the worker in applying for workers' compensation benefits constitutes authorization for any physician, hospital, or other medical vendor to supply relevant information regarding the worker's occupational injury or illness to the insurer, the worker's employer, the worker's representative, or the department. Medical information relevant to a claim includes a past history of complaints of, or treatment of, a condition similar to that presented in the claim. No person who reports to these persons in accordance with Department rules shall bear any legal liability for disclosure of such (ORS 656.252). The physician may require evidence from the representative of his or her representative capacity. The authorization is valid for the duration of the work related injury or illness.

(2) The initial attending physician shall complete the first medical report (Department of Insurance and Finance Form 827) in every detail and mail it to the proper insurer no later than 72 hours after the claimant's first visit (Saturdays, Sundays and holidays will not be counted in the 72-hour period). Diagnoses stated on the 827 and all subsequent reports shall conform to terminology found in the International Classification of Disease-9-Clinical Manifestations (ICD-9-CM) or taught in accredited institutions of the licentiate's profession.

(3) Progress reports are essential. The insurer may require progress reports every 15 days through the use of the physician's supplemental report form (Department of Insurance and Finance Form 828). If more information is

required, the insurer may request a limited or comprehensive narrative report. Progress notes from the clinical chart, if legible, may suffice to give the insurer all the information the insurer needs.

(4) ORS 656.252 requires the attending physician to inform the insurer of the anticipated date of release to work, the anticipated date the worker will become medically stationary and the next appointment date. To the extent the physician can determine these matters they must be included in each progress report. The insurer shall not consider the anticipated date of becoming medically stationary as a release to return to work.

(5) The attending physician shall advise the insurer and the worker within five (5) days of the date the injured worker is released to return to work.

The physician shall not notify the insurer or employer of the worker's release to return to work without notifying the worker at the same time.

(6) The attending physician shall, after a claim has been closed, advise the insurer within five (5) days after treatment is resumed or the reopening of a claim is recommended. The attending physician need not be the same physician who released the worker when the claim was closed.

(7) The attending physician shall promptly respond to the request for progress reports. If the physician or other vendor of services fails to comply with this requirement within 10 days, the insurer may send another request by certified mail, return receipt requested. If within 10 days the physician or other vendor has not complied with this request, penalties under OAR 436-10-110 may be imposed.

(8) Consultations. The attending physician may request consultation regarding conditions related to an accepted claim. The attending physician shall promptly notify the insurer of the referral (referrals to radiologists and pathologists for diagnostic studies are exempt from this requirement). The attending physician shall provide the consultant with all the available clinical information. The consultant shall submit a copy of his consultation report to the attending physician and the insurer within 10 working days of the date of the examination or chart review. No additional fee beyond the consultation fee is allowed for this report.

(9) When an injured worker elects to change attending physicians, the newly selected attending physician shall so notify the insurer not later than five (5) days after the change or the date of first treatment using Department of Insurance and Finance Form 829. The newly selected physician shall make a diligent effort to secure from the previous physician, or from the insurer, all of the available medical information including information concerning previous temporary total disability periods. The previous attending physician shall immediately forward, upon proper request, all requested information and X-rays to the new attending physician.

(10) Injured workers, or their representatives, are entitled to copies of all relevant medical information. This information should ordinarily be available from the insurers, but may be obtained from physicians upon the payment of an appropriate charge for copies. However, reports that contain medical and psychological information relevant to the claim, which in the judgment of the writer of the report should not be shown to the worker because it would not be in the worker's best interest, must be supplied to the worker's representative but need not be supplied to the worker directly. Upon request by the insurer, the director, or the claimant, chart notes containing the relevant information shall be provided subject to the above exception.

Hist: Filed 2/23/82 as Admin. Order 5-1982, eff. 3/1/82
Amended 1/16/84 as Admin. Order 1-1984, eff. 1/16/84
Renumbered from OAR 436-69-101, 5/1/85
Amended 12/10/85 as Admin. Order 6-1985, eff. 1/1/86
Amended 1/20/88 as Admin. Order 1-1988, eff. 2/1/88

Medical Services

436-10-040 (1)(a) The insurer shall pay for all medical services which the nature of the compensable injury or the process of recovery requires. The insurer will not pay for care unrelated to the compensable injury. Services which are unnecessary or inappropriate according to accepted professional standards are not reimbursable. Billings for services which appear to the insurer to be in excess of the standards set forth in these rules, or of generally accepted medical standards, may be referred to the medical director. Such referral shall be made within 60 days of receipt of the bill.

(b) Peer review committees shall be composed of health care providers licensed under the same authority as the health care provider who rendered the services being reviewed. The committees shall provide advice and assistance to the medical director on other health matters when requested. The director may solicit recommendations from professional associations, licensing authorities and professional schools.

(c) The report of such committee shall be submitted to the director who may: (A) issue an order compelling compliance with the judgment of the committee, or (B) forward the report to the insurer and provider for appropriate action.

(2)(a) Frequency and extent of treatment shall not be more than the nature of the injury or the process of a recovery requires. Insurers have the right to require evidence of the efficacy of treatment. The usual range of the utilization of medical services does not exceed 15 office visits by any and all attending physicians in the first 60 days from first date of treatment, and two visits a month thereafter. This statement of fact does not constitute authority for an arbitrary limitation of services, but is a guideline to be used concerning requirements of accountability for the services being provided. Physicians requesting reimbursement for visits in excess of this amount must submit upon request a report documenting the need for such services. Insurer shall notify the physician within 30 days of receipt of the report whether or not the report justifies treatment in excess of the guidelines or justification will be assumed.

(b) A reasonable fee is payable for this report. A judgment by the insurer that the report does not set forth sufficient grounds for the frequency of treatment in excess of the standard may be referred by the physician to the medical director. The medical director may rule in favor of the physician, the insurer, or refer the matter to a peer review committee.

(3) X-ray films must be of diagnostic quality. 14" x 36" lateral views are not reimbursable. Billings for X-rays are not reimbursable without a report of the findings. Upon the request of either the director or the insurer, X-ray films shall be forwarded to the director or the insurer. Films shall be returned to the vendor. A reasonable charge may be made for the costs of delivery of films. Refusal of the physician to forward the films to the director or the insurer upon proper request shall result in nonpayment of the fee for the radiological study.

(4)(a) Physical 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. The treatment plan shall include objectives, modalities, frequency of treatment and duration. A copy of the progress notes shall be provided insurer.

(b) The initial treatment plan shall be for no more than 20 therapy visits in the first 60 days. If more than 20 therapy visits are required in the first 60 days or more than four therapy visits a month after the first 60 days, the physician shall submit a report documenting the need for services in excess of the guidelines upon request of the insurer.

(c) A judgment by the insurer that the report does not justify treatment in excess of the guidelines shall promptly be communicated to the physician and the therapist. The physician may appeal to the medical director who may rule in favor of the physician, the insurer, or refer the matter to a peer review committee.

(d) The preparation of a written treatment plan and supplying progress notes are integral parts of the fee for the therapy service. No additional fee shall be paid except a reasonable amount for copies or summaries of the records of treatment.

(5) The attending physician, when requested to complete a physical capacities evaluation form, shall within 20 days perform an evaluation, if necessary, and complete the form, or refer the worker for such evaluation, or notify the insurer and the worker in writing that the worker is incapable of participating in such evaluation.

(6) Except in an emergency, drugs and medicine for oral consumption supplied by a physician's office are not compensable.

(7) Dietary supplements - such as minerals and vitamins are not reimbursable unless a specific compensable dietary deficiency has been clinically established in the injured worker. Vitamin B-12 injections are not reimbursable unless necessary because of a specific dietary deficiency of malabsorption resulting from compensable gastrointestinal injury.

(8) 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 or 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. Trips to spas, to rest areas or retreats, whether prescribed or in association with a holistic medicine regimen, are not reimbursable unless special medical circumstances are shown to exist.

(9) Prolotherapy is not reimbursable without prior authorization by insurer.

(10) Liquid crystal thermography, photographic or electronic, is not reimbursable without prior authorization. Insurer may require documentation to show why its use is preferable to usual diagnostic tests. Insurer may limit the number of times it may be used in each case.

(11) A written request for authorization for prolotherapy or thermography shall be answered within 14 working days of receipt by insurer or approval will be assumed.

(12) The descriptions of medical services for CPT numbers itemized in (a) through (j) shall be the basis for determining the appropriate level of service.

(a) 95831 - Muscle Testing, Manual, Separate Procedure, Extremity, with Report (also includes 95832, 95833, 95834) - Detailed individual testing of multiple muscles of a patient with a severe neuropathic or myopathic disorder. It does not apply to general or specific muscle testing done during a regular physical examination.

(b) 97110 - Therapeutic Exercises - Instructing a patient in exercises and directly supervising the exercises. Exercising done subsequently by the patient without a physician or therapist present and supervising would not be covered by Code 97110.

(c) 97112 - Neuromuscular Reeducation - The provision of direct services to a patient who has had muscle paralysis and is undergoing recovery or regeneration. Examples would be severe trauma to nervous system, cerebral vascular accident and systemic neurological disease. The code does not apply to massaging or exercising relatively normal muscles or treatment of minor disuse atrophy, e.g. following cast removal.

(d) 97114 - Functional Activities - The development and instruction in specific activities for persons who are severely handicapped or debilitated. The code does not apply to routine exercises for relatively normal individuals.

(e) 97116 - Gait Training - Teaching individuals with severe neurological or muscular-skeletal disorders to ambulate in the face of their handicap or to ambulate with an assistive device. This code does not apply to simple instructions given relatively normal individuals with minor or transient abnormalities of gait who do not require an assistive device.

(f) 97220 - Hubbard Tank - This service involves a full-body immersion tank for treating severely burned, debilitated and/or neurologically impaired individuals.

(g) 97240 - Pool Therapy with Therapeutic Exercises - This service is provided individually, in a pool, to severely debilitated or neurologically impaired individuals. It does not apply to relatively normal individuals who exercise, swim laps or relax in a hot tub or Jacuzzi.

(h) 97540 - Activities of Daily Living - Services provided in an office or clinic to severely impaired individuals, e.g. how to get in and out of a tub; how to make a bed; how to prepare meals in a kitchen. It does not apply to simple instructions or counseling in body mechanics given briefly to a patient.

(i) 97720 - Extremity Testing for Strength, Dexterity, or Stamina - Detailed testing of a patient with a generalized neurological or debilitating disease. It does not apply to routine physical examinations of relatively unimpaired individuals.

(j) 97740 - Kinetic Activities - When there are major impairments or disabilities which preclude the patient performing the activities and exercises that are ordinarily prescribed. Considerable time is spent developing specific, individualized therapeutic exercises and instructing the patient in how to perform them. This code does not apply to instructions in routine exercises.

Hist: Filed 2/23/82 as Admin. Order 5-1982, eff. 3/1/82
Amended 1/16/84 as Admin. Order 1-1984, eff. 1/16/84
Amended 8/20/84 as Admin. Order 5-1984, eff. 8/20/84
Amended 4/29/85 as Admin. Order 2-1985, eff. 6/3/85;
Renumbered from OAR 436-69-110, 5/1/85

Amended 12/10/85 as Admin. Order 6-1985, eff. 1/1/86
Amended 2/20/87 as Admin. Order 2-1987, eff. 3/16/87
Amended 1/20/88 as Admin. Order 1-1988, eff. 2/1/88

436-10-045 (1) If an insurer, worker or the director feels that any medical treatment recommended for, or provided to, a worker or workers, is unscientific, unproven, outmoded or experimental, either party may request, or the director may initiate on the director's own, an investigation.

(2) The investigation shall include the advice of the licensing boards of practitioners who might be affected.

(3) The director may submit the record of the investigation to the Advisory Committee on Medical Care which shall review the record and conduct any further inquiry the committee considers necessary. The committee shall render a recommendation to the director as to whether or not the committee considers the treatment in question to be unscientific, unproven, outmoded or experimental.

(4) The director may adopt a rule declaring the treatment to be noncompensable.

(5) No sums deleted by an insurer under the rule referred to in (4) above shall be charged to a worker.

Hist: Filed 1/20/88 as Admin. Order 1-1988, eff. 2/1/88

Medical Panels

436-10-046 (1) If a worker, insurer or the director believes a worker's treatment is excessive, inappropriate, ineffectual or in violation of the medical rules either may request, and the director may establish on the director's own motion, a medical panel.

(2) Any party requesting a review shall notify all other parties, including the medical provider, at the same time the request is made to the director. If the director initiates the panel the director shall notify the parties.

(3) No later than five days after receiving the request the director shall notify the parties whether or not a panel will be authorized and shall inform the parties of their responsibilities in the matter.

(4) Once the panel is authorized, the insurer shall not deny the claim for medical services, nor shall the worker request a hearing on any issues subject to the director's jurisdiction, until an order is issued.

(5) The panel, composed of Oregon physicians whose treatment is not under review and licensed in the same healing art as the physician whose treatment is under review, shall be established as follows:

(a) No later than 10 days after the director authorizes the panel the worker and the insurer shall each choose a physician and notify the director.

(b) If either the worker or the insurer fails to inform the director of the physician chosen in the allotted time, the director shall choose the physician.

(c) The two physicians shall choose a third physician no later than 20 days after the director authorizes the panel.

(d) If the third physician is not chosen in the allotted time, the director shall choose the third panel member.

(e) The director shall inform the panel the date the panel's report is due, which will be no later than 40 days after the selection of the panel is complete.

(6) The director shall inform the worker of the date, time, and location of the examination with copies to the insurer, attending physician and panel members.

(7) The insurer and attending physician shall forward all pertinent medical records, laboratory results and X-rays to the medical panel.

(8) The medical panel may:

(a) Review all medical records and X-rays submitted.

(b) Interview and examine the worker.

(c) Perform any necessary tests, laboratory studies and X-rays except invasive tests.

(d) Submit a report in writing to the director containing the panel's recommendation, with copies to the worker, insurer, and attending physician.

(9) The recommendation may include, but not be limited to:

(a) Reason for the panel examination.

(b) Past medical history.

(c) Current medical problem.

(d) Current treatment

(e) Results of the examination.

(f) Results of tests performed.

(g) Diagnosis.

(h) The medically stationary status.

(i) Whether current treatment is excessive, inappropriate or ineffectual.

(j) Whether or not the current treatment should be continued, modified or terminated.

(10) Within 10 days of receipt of the report the director shall issue a final order.

Hist: Filed 1/20/88 as Admin. Order 1-1988, eff. 2/1/88

Choosing And Changing Doctors

436-10-060 (1) A newly selected attending physician shall notify the insurer not later than five (5) days after the date of change or first treatment, using Form 829 (Change of Attending Physician).

(2) The patient may have only one attending physician at a time. Treatment by other physicians shall be at the request of the attending physician who shall promptly notify the insurer of the request. Fees for treatment by more than one physician at the same time are payable only when the medical conditions present are related to the treatment of the compensable injury or illness and are sufficiently different that separate medical skills are needed for proper treatment.

(3) The worker is allowed to change physicians by choice two times after the initial choice. Referral by the attending physician to another attending physician shall not count in this calculation. Examinations at the request of the insurer, and consultations requested by the attending physician, do not constitute a change in attending physician.

(4) When a worker has made an initial choice of attending physician and subsequently changed two times, the insurer shall inform the worker by certified mail that any subsequent changes must have the approval of the insurer or the director.

In the event that the worker again changes physician without the approval of the insurer, the insurer may deny payment for services rendered by the additional physician and inform the claimant of the right to seek approval of the director.

If a physician begins treatment without being informed that the worker has been given the required notification the insurer shall pay for appropriate services rendered prior to the time the insurer notifies the physician that further payment will not be made.

Hist: Filed 2/23/82 as Admin. Order 5-1982, eff. 3/1/82
Amended 1/16/84 as Admin. Order 1-1984, eff. 1/16/84
Amended 4/29/85 as Admin. Order 2-1985, eff. 6/3/85;
Renumbered from OAR 436-69-401, 5/1/85
Amended 1/20/88 as Admin. Order 1-1988, eff. 2/1/88

Charges And Fees

436-10-090 (1) All billings shall be fully itemized and services identified by code numbers and descriptions found in the Current Procedural Terminology or as described in OAR 436-10-040(12)(a) through (j). Hospitals may bill for inpatient services and surgery using the International Classification of Diseases, 9th edition--with Clinical Manifestations (ICD9-CM).

(2) When services are provided in hospital emergency or outpatient departments which are similar to or identical with services provided in physician or physical therapist offices, such services shall be identified by CPT codes and reimbursed at no more than the 75th percentile as shown in the department's relative value schedule. Such services include outpatient physical therapy, outpatient X-rays and emergency department treatment and physician's services.

When a worker is seen initially in an emergency department and is then admitted to the hospital for inpatient treatment, the services provided immediately prior to admission shall be considered part of the inpatient treatment.

(3) Any service billed with a code number commanding a higher fee than the services provided shall be returned to the vendor for correction or paid at the value of the service provided. Any service not identifiable with a code number shall be adequately described.

(4) The vendor of medical services shall bill the vendor's usual fee charged to the general public. The submission of the bill by the vendor shall serve as a warrant that the fee submitted is the usual fee of the vendor for the services rendered. The department shall have the right to require documentation from the vendor establishing that the fee under question is the vendor's usual fee charged to the general public.

(5) In all cases of accepted compensable injury or illness under jurisdiction of the Workers' Compensation Law, the injured worker is not liable for payment for any services for the treatment of that injury or illness. The vendor of medical services may charge the patient directly only for the treatment of conditions that are unrelated to the accepted compensable injury or illness.

(6) The insurer may not pay any more than the vendor's usual fee to the general public and, under ORS 656.248, shall in no case pay more than the 75th percentile of the usual and customary fees as determined by the director. The vendor may not attempt to collect from the injured worker any sums deleted by the insurer.

In the event of a dispute about fees between the vendor and the insurer, either may appeal to the medical director. The medical director will investigate and advise the director who may issue an order advising either party to comply. If orders are issued, either party may request a hearing pursuant to OAR 436-10-110(5).

(7) For those medical services for which no CPT code or relative value has been established the director shall determine which services are most commonly provided to injured workers and promulgate a reasonable rate for the services, which shall be the same for all primary health care providers. Such services include, but are not limited to, brief narrative report and complete narrative report.

(8) The director shall review and update medical fees annually using data from a statistically valid survey, the physician service component of the National Consumer Price Index, or from any state agency having access to usual and customary medical fee information. The fees at the 75th percentile, as determined by the director, are published as Appendix "A".

(9) Physician assistants or nurse practitioner fees will be paid at the rate of 80 percent of a physician's fee for a comparable service except that assisting in surgery shall be paid at the rate of 50 percent of the comparable fee for a physician assisting in surgery.

(10) Billings for treatment shall be rendered at reasonable intervals not to exceed 60 days following treatment. Late billings will be subject to discounts, not to exceed 10 percent, for each 30 day period or fraction thereof, beyond 60 days.

(11) Billings shall include the claimant's full name, date of injury, the employer's name and, if available, the insurer's claim number. Billings not correctly filled out may be returned to the vendor for correction and resubmission.

(12) Laboratory fees shall be billed in accordance with ORS 676.310. If the attending or consulting physician submits a bill for laboratory services that were performed in an independent laboratory, the bill shall show the amount charged by the laboratory and any service fee that the attending or consulting physician charges.

(13) The definitions of commonalty in the guidelines found in the Current Procedural Terminology shall be used as guides governing the descriptions of services.

(14) Only one office visit designation may be used at a time except for those code numbers relating specifically to additional time.

(15) Physician mark-up shall not exceed 20 percent for braces, supports and other medical devices with a unit price greater than $25. Invoices for these devices shall be provided on request of insurer.

(16) Fees for surgical procedures shall be billed as follows:

(a) When two surgeons operate and one performs a discectomy and one performs an arthrodesis, each procedure is to be billed separately. The maximum allowable fee for each procedure, as listed in the Relative Value Schedule, shall be reduced by 25 percent.

When the surgeons assist each other throughout the operation each may bill an additional fee of 20 percent of the other surgeon's fee as an assistant's fee.

When the surgeons do not assist each other, and a third physician assists the surgeons, the third physician is entitled to the assistant's fee of 20 percent of the surgeons' fees.

(b) When one surgeon performs a discectomy and arthrodesis the procedure shall be billed under CPT Codes 22550-22565 and/or CPT Codes 22730-22735.

(c) When multiple surgical procedures are performed, the principal procedure is reimbursed at 100 percent of the maximum allowable fee, the secondary procedure is reimbursed at 50 percent of the maximum allowable fee and all subsequent procedures are reimbursed at 25 percent of the maximum allowable fee.

(d) When multiple arthroscopic procedures are performed, the major procedure shall be paid at no more than 100 percent of the value in the RVS and the subsequent procedures paid at 10 percent of the value listed in the RVS.

(e) Surgery following severe trauma, for which several procedures are required and which take considerable time, and for which the surgeon feels his fees should not be reduced, can receive special consideration by the insurer. Such a request must be accompanied by written documentation and justification.

(f) Hospital charges for inpatient myelograms are not subject to the Relative Value Schedule. Physician's services for inpatient myelograms are subject to the Relative Value Schedule.

(17) When two bills are submitted for an X-ray, one by the person taking the X-ray (technical component) and one by the radiologist who interprets the X-ray (professional component), the maximum allowable fee is to be divided between them.

The technical component is reimbursed at 60 percent of the maximum allowable fee and the professional component is reimbursed at 40 percent of the maximum allowable fee.

(18) Outpatient hospital service shall be billed as follows:

(a) The maximum allowable fees for X-ray and physical therapy, as determined by the Relative Value Schedule, are to be applied to hospital bills only for outpatient services.

(b) CAT scans, when performed as an outpatient service, are subject to the limitations of the Relative Value Schedule. When multiple areas are examined by CAT scan, the first area examined shall be reimbursed at 100 percent, the second area at 50 percent and the third and all subsequent areas at 25 percent of the Relative Value Schedule.

(19) A physical medicine modality, when applied to two or more areas at one visit, shall be reimbursed at 100 percent of the maximum allowable fee for the first area treated, 50 percent for the second area treated, and 25 percent for all subsequent areas treated.

(20) Fees for reports:

a. A medical service provider may not charge any fee for completing a medical report form required by the director under this chapter.

b.	Copies of office progress notes when requested by insurer -	$3.50 for 1st page, $ .50 a page thereafter
c.	Brief Narrative -	Summary of Rx to date and current status; answer to 3-5 specific questions - $25
d.	Complete narrative -	Past history, history of present illness, treatment to date, current status, impairment, prognosis, medically stationary? - $50

(21) Fee for a deposition (Includes preparation time):

a.	First hour	$300
b.	Each subsequent hour	$100

(22) When a provider of medical services, including a hospital, submits a bill to an insurer for medical services, the provider shall submit a copy of such bill to the worker to whom the services were provided.

The copy to the worker shall be stamped or printed with a legend that clearly indicates that it is a copy and is not to be paid by the worker.

(23) When multiple areas are examined using Magnetic Resonance Imaging (MRI) the first area examined shall be reimbursed at 100 percent, the second area at 50 percent and the third and all subsequent areas at 25 percent of the Relative Value Schedule.

(24) Mechanical muscle testing shall be reimbursable three times during a treatment program: once near the beginning, once near the middle and once near the end of the treatment program. Additional mechanical muscle testing is reimbursable only when the testing has been prior authorized by the insurer.

The fee for mechanical muscle testing includes an interpretation of the results and a report.

Hist: Filed 2/23/82 as Admin. Order 5-1982, eff. 3/1/82
Amended 1/16/84 as Admin. Order 1-1984, eff. 1/16/84
Amended 4/29/85 as Admin. Order 2-1985, eff. 6/3/85;
Renumbered from OAR 436-69-701, 5/1/85
Amended 1/20/88 as Admin. Order 1-1988, eff. 2/1/88

Advisory Committee on Medical Care

436-10-095 (1) The Advisory Committee on Medical Care shall be appointed by the director pursuant to ORS 656.794.

(2) Committee members shall be reimbursed necessary travel and other expenses from the administrative fund.

(3) Committee members shall submit to the director, no later than the end of the quarter the expenses were incurred, a standard expense voucher for reimbursement.

(4) The committee shall elect a chairman and vice chairman from its members and establish their terms of office.

(5) The committee shall consist of two Doctors of Medicine, one Doctor of Osteopathy, one Doctor of Chiropractic, one Doctor of Naturopathy and either one Doctor of Dental Surgery or one Doctor of Dental Medicine, all of whom shall be qualified to be attending physicians. The committee shall also include one representative each of insurers, employers and workers.

(6) The members shall serve at the pleasure of the director.

(7) The duties of the committee shall include:

(a) To advise the director on matters relating to the provision of medical care to injured workers.

(b) To review proposed standards for medical evaluation of disabilities, and any proposed future changes in the standards, and to make recommendations to the director.

(c) To prepare and submit to the director rules governing the provision of medical care for compensable conditions, including the rates for medical service, and to advise the director on any other proposed rules regarding medical care.

(d) To advise the director on medical care questions.

(8) The medical director shall provide liaison between the committee and the director and shall provide staff and administration support to the Committee.

Hist: Amended 1/20/88 as Admin. Order 1-1988, eff. 2/1/88

Insurer's Rights and Duties

436-10-100 (1)(a) The Director or insurer may obtain medical examinations of the worker by physicians of their choice. The number of such examinations is limited by ORS 656.325. In the event the insurer believes that a need exists for more than three examinations, the insurer shall request approval of the director. In arriving at a decision the director will consider such matters as the date of injury, date of last examination, nature of examinations that have been performed, the complexities of the medical issues. The worker shall be notified of the purpose of the examination. Such examinations shall be at places, times, and intervals reasonably convenient to the worker, and shall not delay or interrupt proper treatment of the worker.

(b) The examiner shall promptly send a copy of the report to the attending physician and the insurer or person requesting the exam.

(c) Any physician who unreasonably and without good cause interferes with the right of the insurer to obtain examination by physicians of their choice may be subject to penalties.

(d) Independent Medical Examination (IME) is a special consultation which may be requested only by the insurer or with the insurer's prior authorization. The fee for an IME is to be agreed upon prior to the examination. When a worker known to be represented by a lawyer is scheduled for an IME, the worker's lawyer shall be sent simultaneously a copy of the notification sent to the worker.

(e) When a worker is required to attend an IME the insurer shall pay for the examination and all necessary related services which include, but are not limited to, child care, travel, meals and lodging. The insurer shall reimburse the worker within 60 days of receipt of an itemized bill and appropriate receipts.

(2) An examination obtained at the request of the Evaluation Section is not considered one of the three examinations allowed to the insurer.

(3) Insurer shall pay bills for medical services within 60 days of receipt of the bill, if the billing is submitted in proper form and clearly shows that the treatment is related to the accepted compensable injury or disease. Failure to do so shall render insurer liable to pay a reasonable monthly service charge after the 60th day, if the provider customarily levies such a service charge to the general public.

(4) In claims which have been denied and are on appeal, the insurer shall notify the vendor promptly of any change of status of the claim.

(5) In the event of a dispute over portions of a billing, the insurer shall pay within 60 days the undisputed portion of the bill.

(6) In the event a vendor of medical services feels aggrieved by the conduct of an insurer, the vendor may request the assistance of the department. If the matter involves treatment or fees, the matter shall be resolved pursuant to OAR 436-10-040(4). If the matter involves actions of the insurer and cannot be resolved informally, the director may issue an order compelling compliance and setting forth the appeal rights of the parties.

(7) The limitations of the workers' right to choose attending physicians (ORS 656.245) and the insurer's right to independent examinations (656.325) begin with the date of injury and extend through the life of the claim. Exceptions to both limitations will be handled on a case by case basis.

(8) The insurer shall establish an audit program for bills for all medical services to determine that services are billed as provided, that appropriate prescriptions and treatment plans are completed in a timely manner, that payments do not exceed the maximum in the Relative Value Schedule and that bills are submitted in a timely manner.

The audit shall be continuous and shall include no fewer than 10 percent of medical bills.

Hist: Filed 2/23/82 as Admin. Order 5-1982, eff. 3/1/82
Amended 1/16/84 as Admin. Order 1-1984, eff. 1/16/84
Renumbered from OAR 436-69-801, 5/1/85
Amended 12/10/85 as Admin. Order 6-1985, eff. 1/1/86
Amended 1/20/88 as Admin. Order 1-1988, eff. 2/1/88

Complaint Procedures And Penalties

436-10-110 (1) Complaints shall be directed to the medical director. Complaints shall be in writing and fully documented. If the medical director believes the complaint may have merit, the medical director may investigate the matter and afford the party complained of an opportunity to respond to the allegations. The medical director may consult with an appropriate committee of the physician's peers before presenting a recommendation to the director.

(2) The medical director shall upon completion of his investigation recommend an appropriate disposition to the director. The medical director may recommend, and the director may elect, not to investigate the matter or issue an order but rather refer the matter to a referee. Notwithstanding ORS 183.315(1) the conduct of hearings and the judicial review thereof shall be as provided in ORS 183.310 to 183.550, except that:

(a) The order of the referee shall be a final order of the director;

(b) The director shall have the same right to a judicial review of the order of a referee as any person who is adversely affected or aggrieved by such final order.

(3) If the medical director finds any violation of OAR 436-10-040, 436-10-050, 436-10-060, 436-10-090 or 436-10-100(1)(c) the medical director may recommend to the director, and the director may impose, one or more of the following sanctions;

(a) Reprimand by the director;

(b) Nonpayment or recovery of fees in part, or whole, for services rendered;

(c) Referral to the appropriate licensing board.

(4) If the medical director finds any violation of the rules enforcing the provisions of ORS 656.252 and 656.254 as found in OAR 436-10-030, 436-10-070 and 436-10-080 of these rules, the medical director may recommend to the director, and the director may impose, one or more of the following sanctions:

(a) Reprimand by the director;

(b) Nonpayment or recovery of fees in part, or whole, for services rendered;

(c) Referral to the appropriate licensing board; or

(d) Civil penalty not to exceed $1,000 for each occurrence. The maximum penalty shall be levied only upon repeated or willful violation. In determining the amount of penalty to be assessed, the director shall consider:

(A) The degree of harm inflicted on the worker or the insurer;

(B) Whether there have been previous violations; and

(C) Whether there is evidence of willful violations.

(5) A hearing relating to a proposed order issued under these rules shall be held by a referee of the Hearings Division of the Workers' Compensation Board. A hearing shall not be granted unless a request for hearing is filed within 30 days of receipt of the proposed order. If a request for hearing is not so filed, the order, as proposed, shall be a final order of the department. Notwithstanding ORS 183.315(1) the conduct of hearings and the judicial review thereof shall be as provided in ORS 183.310 to 183.550, except that:

(a) The order of the referee shall be a final order of the director; and

(b) The director shall have the same right to judicial review of the order of a referee as any person who is adversely affected or aggrieved by such final order.

(6) Insurers who violate these rules shall be subject to the penalties in ORS 656.745.

(7) (a) Under the provisions of ORS 183.310 to 183.550 the director may impose a penalty of forfeiture of fees and a fine not to exceed $1,000 for each occurrence any health care practitioner who, pursuant to ORS 656.254, has been found to:

A. Fail to comply with the medical rules; or

B. Provide medical treatment that is excessive, inappropriate or ineffectual; or

C. Engage in any conduct demonstrated to be dangerous to the health or safety of a worker.

(b) If the conduct as described in paragraph (a) above is found to be repeated and willful, the director may declare the practitioner ineligible for reimbursement for treating workers' compensation claimants for a period not to exceed three years.

(c) A health care practitioner whose license has been suspended or revoked by the licensing board for violations of professional ethical standards may be declared ineligible for reimbursement for treating workers' compensation claimants for a period not to exceed three years.

A certified copy of the revocation or suspension order shall be prima facie justification for the director's order.

(d) (a) If an insurer or worker believes penalties under (a) and/or (b) of this section are appropriate, either may submit, in writing, to the director:

(A) Practitioner's name and address;

(B) Claimant's name and claim number;

(C) Reason penalties are thought to be warranted;

(D) Any harm which has befallen, or might befall, the claimant;

(E) Specific examples of failure to comply with the medical rules;

(F) Reasons treatment is thought to be inappropriate, excessive or ineffectual; and,

(G) Reports from any medical consultants supporting the insurer's or worker's position.

(e) The director shall investigate the allegations and may seek advice from the Advisory Committee on Medical Care, practitioner's licensing boards, professional associations or a medical panel established under OAR 436-10-046.

(f) If the director believes, upon completion of the investigation, that penalties may be in order the director shall issue a complaint and proceed to a contested case hearing under the provisions of ORS 183.310 to 183.550.

(g) At the completion of the hearing, and upon receipt of the hearing officer's report, the director may adopt the hearings officer's recommendations or issue an order of the director imposing penalties.

Hist: Filed 2/23/82 as Admin. Order 5-1982, eff. 3/1/82
Amended 1/16/84 as Admin. Order 1-1984, eff. 1/16/84
Renumbered from OAR 436-69-901, 5/1/85
Amended 1/20/88 as Admin. Order 1-1988, eff. 2/1/88

APPENDIX A

OREGON RELATIVE VALUE SCHEDULE FOR MEDICAL SERVICE

(1) The coding structure is that of the Current Procedural Terminology (CPT), Fourth Edition, 1985.

(2) There are five sections, each of which has its own schedule of relative values which is completely independent of and unrelated to any of the other four sections.

(3) In each section the code unit is followed by a relative value number, when such has been established. When no value has been established, the provider must submit with the billing a description of the service in detail sufficient for the payor to judge whether the fee is reasonable.

(4) In the surgery section, a third column shows the number of days of post-operative care included in the fee.

(5) In the radiology section, the second column shows the total value of an examination, i.e., costs of X-ray film, interpretation and making a report of the study.

(6) Physicians who inject air, contrast material or isotopes as part of a radiologic study shall bill for this service using CPT codes from the surgery section, e.g. 62284 - injection for myelography.

(7) The Definitions and Items of Commonalty, Current Procedural Terminology, pp. xiv - xviii, 1985, and the definitions in OAR 436-10-040(12), shall be the basis for determining levels of service. A disagreement about the level of service may be referred, by the physician, to the Medical Director, who may resolve the issue in favor of either party.

APPENDIX A:

CHANGE OF CPT NO.	RELATIVE VALUE
22325	BR
22326	BR
22327	BR
22720	18.5
27131	30.0
27135	34.0
35161	13.5
45330	0.8
45331	1.0
45332	1.0
52000	1.2
52005	2.1
70551-026 PC*	12.0
70551-027 TC*	54.0
72141-026 PC*	12.0
72141-027 TC*	54.0
73720-026 PC*	12.0
73720-027 TC*	54.0

*PC - Professional component
TC - Technical component

72296	12.2
78300	11.5
78305	16.0
78306	20.0
78310	25.0
78315	30.0
97752	(1) Extremity, 1 plane of motion - 8.7 (2) Extremity, 2 or more planes of motion - 10.9 (3) Trunk, includes cervical, thoracic and L-S Spine - 15.9

BEFORE THE DIRECTOR OF THE
DEPARTMENT OF INSURANCE AND FINANCE
OF THE STATE OF OREGON

In the Matter of the Amendment of Rules Governing Claims Administration (OAR Chapter 436, Workers' Compensation Division, Division 60).	)))))	ORDER OF ADOPTION

The Director of the Department of Insurance and Finance, pursuant to his general rule making authority under ORS 656.726(3) and in accordance with the procedure provided by ORS 183.335, amends OAR Chapter 436, Workers' Compensation Division, Division 60, Claims Administration.

On October 1, 1987, the Workers' Compensation Division filed Notice of Public Hearing with the Secretary of State to amend rules governing claims administration. The Statement of Need and Legal Authority and the Statement of Fiscal Impact were also filed with the Secretary of State.

Copies of the notice were mailed to interested persons in accordance with ORS 183.335(7) and OAR 436-01-000 and to those on the Division's distribution mailing list as their interest indicated. The notice was published in the October 15, 1987, Secretary of State's Administrative Rule Bulletin.

On November 3, 1987, the public hearing was held as announced. A summary of the written testimony and agency responses thereto is contained in Exhibit "C." This summary is on file and available for public inspection between the hours of 8 a.m. and 5 p.m., normal working days Monday through Friday in the Administrator's Office, Workers' Compensation Division, Room 200, Labor & Industries Bldg, Salem, Oregon 97310.

Having reviewed and considered the record of public hearing and being fully advised, I make the following findings:

a. The applicable rule making procedures have been followed.
b. The rules are within the Director's authority.
c. The rules being adopted are a reasonable administrative interpretation of the statutes and are required to carry out statutory responsibilities.

IT IS THEREFORE ORDERED THAT:

(1) Rules Governing Claims Administration, OAR Chapter 436, Division 60, as set forth in Exhibit "A" attached hereto, certified a true copy and hereby made part of this order, is adopted effective January 1, 1988.

(2) A certified true copy of the Order of Adoption and these rules, with Exhibit "B" consisting of the Citation of Statutory Authority, Statement of Need, Documents Relied on and Fiscal Impact Statement, attached hereto and hereby made a part of this order, be filed with the Secretary of State.

(3) A copy of the rules and attached Exhibit "B" be filed with the Legislative Counsel pursuant to the provisions of ORS 183.715 within ten days after filing with the Secretary of State.

Dated this 18 day of December, 1987.

Department of Insurance and Finance

Theodore R. Kulongoski

Theodore R. Kulongoski, Director

EXHIBIT "A"

CHAPTER 436
DEPARTMENT OF INSURANCE AND FINANCE
WORKERS' COMPENSATION DIVISION
DIVISION 60, CLAIMS ADMINISTRATION

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AUTHORITY FOR RULES

436-60-001 These rules are promulgated under the Director's authority contained in ORS 656.210(2), 656.264, 656.265(6), 656.325, 656.331 and 656.726(3).

Hist: Filed 12/19/75 as WCB Admin. Order 18-1975, eff. 1/1/76
Amended 4/27/78 as WCD Admin. Order 6-1978, eff. 4/27/78
Amended 1/11/80 as WCD Admin. Order 1-1980, eff. 1/11/80
Amended 12/29/83 as WCD Admin. Order 8-1983, eff. 1/1/84
Renumbered from 436-54-001, May 1, 1985
Amended 12/12/85 as WCD Admin. Order 8-1985, eff. 1/1/86

PURPOSE

436-60-002 It is the purpose of the Director that under the provisions of ORS 656.726(3) rules be established to allow insurers to uniformly process claims. One of the general charges to the Director under the Workers' Compensation Law is ". . . regulation and enforcement of . . . ORS 656.001 to 656.794." To meet that responsibility the Director has delegated to Compliance the responsibility of ensuring the requirements of the statutes, rules and bulletins of the Department are complied with as they relate to claims processing. To that end, when it comes to the attention of Compliance that an insurer is not processing a claim in accordance with the requirements of the law, Compliance will so notify the insurer and request immediate appropriate action. If the appropriate action is not taken by the insurer in accordance with the law the insurer will be subject to civil penalty under ORS 656.745.

Hist: Filed 4/27/78 as WCD Admin. Order 6-1978, eff. 4/27/78
Amended 1/11/80 as WCD Admin. Order 1-1980, eff. 1/11/80
Amended 12/29/83 as WCD Admin. Order 8-1983, eff. 1/1/84
Renumbered from 436-54-008, May 1, 1985
Amended 12/12/85 as WCD Admin. Order 8-1985, eff. 1/1/86
Amended 12/18/87 as WCD Admin. Order 4-1987, eff. 1/1/88

APPLICABILITY OF RULES

436-60-003 These rules are effective January 1, 1988, to carry out the provisions of:

(1) ORS 656.210 - Temporary total disability

(2) ORS 656.212 - Temporary partial disability

(3) ORS 656.230 - Lump sum payments with Department approval

(4) ORS 656.245 - Medical services to be provided; choice of doctor

(5) ORS 656.262 - Responsibility for processing and payment of compensation; sight drafts; acceptance and denial of claim; reporting claims; penalties for payment delays

(6) ORS 656.264 - Compensable injury, claim and other reports

(7) ORS 656.265 - Notice of accident from worker

(8) ORS 656.268 - Insurer claim closures

(9) ORS 656.307 - Determination of issues regarding responsibility for compensation payment

(10) ORS 656.325 - Required medical examination; suspension of compensation; injurious practices; claimant's duty to reduce disability; reduction of benefits for failure to participate in rehabilitation

(11) ORS 656.331 - Notice to worker's attorney

(12) ORS 656.726(3) - Department powers and duties generally

Hist: Filed 4/27/78 as WCD Admin. Order 6-1978, eff. 4/27/78
Amended 1/11/80 as WCD Admin. Order 1-1980, eff. 1/11/80
Amended 12/23/81 as WCD Admin. Order 6-1981, eff. 1/1/82
Amended 12/29/83 as WCD Admin. Order 8-1983, eff. 1/1/84
Amended 4/4/84 as WCD Admin. Order 3-1984, eff. 4/4/84
Renumbered from 436-54-003, May 1, 1985
Amended 12/12/85 as WCD Admin. Order 8-1985, eff. 1/1/86
Amended 12/18/87 as WCD Admin. Order 4-1987, eff. 1/1/88

DEFINITIONS

436-60-005 For the purpose of these rules unless the context requires otherwise:

(1) "Aggravation" means the worsened condition of an injured worker which is a medically verified increase in seriousness or severity of a condition arising from an industrial injury to the worker since the last award or arrangement of compensation for that industrial injury.

(2) "Attending Physician" means a doctor or physician who accepts the primary responsibility for the treatment of a worker's compensable injury.

(3) "Board" means the Workers' Compensation Board of the Department of Insurance and Finance.

(4) "Claim" means a written request for compensation from a subject worker or someone on the worker's behalf, or any compensable injury of which a subject employer has notice or knowledge.

(5) "Compliance" means the Compliance Section of the Workers' Compensation Division of the Department of Insurance and Finance.

(6) "Department" means the Department of Insurance and Finance.

(7) "Determination" means examination of the worker's claim for compensation by Evaluation.

(8) "Director" means the Director of the Department of Insurance and Finance or the Director's delegate for the matter.

(9) "Division" means the Workers' Compensation Division of the Department of Insurance and Finance, consisting of the Compliance Section, Evaluation Section and Rehabilitation Review Section.

(10) "Employment on call" means sporadic, unscheduled employment on call by an employer with no right of reprisal if employe unavailable.

(11) "Employment through union hall" means workers who report to union halls for job placement.

(12) "Evaluation" means the Evaluation Section of the Workers' Compensation Division of the Department of Insurance and Finance.

(13) "Health insurance," as defined under ORS 731.162, means insurance of humans against bodily injury, disablement or death by accident or accidental means, or the expense thereof, or against disablement or expense resulting from sickness or childbirth, or against expense incurred in prevention of sickness, in dental care or optometrical service, and every insurance appertaining thereto. "Health insurance" does not include workers' compensation coverage.

(14) "Insurer" means the State Accident Insurance Fund Corporation, an insurer authorized under ORS Chapter 731 to transact workers' compensation insurance in this state or an employer or employer group who has been certified under ORS 656.430 that the employer or employer group meets the qualifications of a self-insured employer set out by ORS 656.407.

(15) "Loss of earning power" means the difference between wage earnings of the worker from the employment at the time of and giving rise to the injury and the wage earnings available from any kind of work approved by the attending physician prior to claim determination which is available to the injured worker, whether or not the work is accepted or performed.

(16) "Lump sum" means the payment of all or any part of a permanent partial disability award in one payment.

(17) "Medical Director" means the Medical Director in the office of the Director of the Department of Insurance and Finance.

(18) "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.

(19) "Paying Agent" means the insurer responsible for paying compensation for a compensable injury.

(20) "Physical rehabilitation program" means any disability prevention services which include physical restoration provided a worker.

(21) "Process claims" means the receipt, review and payment of compensation of claims of workers.

Hist: Filed 4/27/78 as WCD Admin. Order 6-1978, eff. 4/27/78
Amended 1/11/80 as WCD Admin. Order 1-1980, eff. 1/11/80
Amended 12/23/81 as WCD Admin. Order 6-1981, eff. 1/1/82
Amended 12/29/83 as WCD Admin. Order 8-1983, eff. 1/1/84
Renumbered from 436-54-005, May 1, 1985
Amended 12/12/85 as WCD Admin. Order 8-1985, eff. 1/1/86
Amended 12/18/87 as WCD Admin. Order 4-1987, eff. 1/1/88

ADMINISTRATION OF RULES

436-60-006 Any orders issued by the Division in carrying out the Director's authority to enforce ORS Chapter 656 and the rules adopted pursuant thereto, are considered orders of the Director.

Hist: Filed 4/27/78 as WCD Admin. Order 6-1978, eff. 4/27/78
Amended 1/11/80 as WCD Admin. Order 1-1980, eff. 1/11/80
Amended 12/29/83 as WCD Admin. Order 8-1983, eff. 1/1/84
Renumbered from 436-54-010, May 1, 1985
Amended 12/12/85 as WCD Admin. Order 8-1985, eff. 1/1/86
Amended 12/18/87 as WCD Admin. Order 4-1987, eff. 1/1/88

ADMINISTRATIVE REVIEW

436-60-008 (1) Any party aggrieved by an action taken pursuant to these rules involving any matter concerning a claim may request a hearing by the Hearings Division of the Workers' Compensation Board in accordance with ORS Chapter 656 and the Board's Rules of Practice and Procedure for Contested Cases under the Workers' Compensation Act.

(2) Any party aggrieved by an action taken pursuant to these rules involving all matters other than those concerning a claim may request a hearing of the Director.

(a) The Director shall forward the request for a hearing to the Department of Justice with pertinent records in the matter as requested.

(b) The Department of Justice shall forward the request and other pertinent information to the Hearings Division.

(c) Notwithstanding ORS 183.315(1), the issuance of orders under these rules, the conduct of hearings and the judicial review thereof by the Court of Appeals shall be as provided in ORS 183.415 through ORS 183.495 except:

(A) the Board may promulgate rules for the conduct of the hearings under these rules;

(B) the order of the hearing referee shall be deemed to be a final order of the Director; and

(C) the Director shall have the same right to a judicial review of the order of the hearing referee as any person who is adversely affected or aggrieved by such final order.

Hist: Filed 4/27/78 as WCD Admin. Order 6-19-78, eff. 4/27/78
Amended 1/11/80 as WCD Admin. Order 1-1980, eff. 1/11/80
Amended 12/29/83 as WCD Admin. Order 8-1983, eff. 1/1/84
Renumbered from 436-54-998, May 1, 1985
Amended 12/12/85 as WCD Admin. Order 8-1985, eff. 1/1/86

REPORTING REQUIREMENTS

436-60-010 (1) A subject employer shall accept notice of a claim for workers' compensation benefits from any injured worker or their representative. Employers, except self-insured employers processing their own claims, shall immediately and not later than five days after notice or knowledge of any claim or accident which may result in a compensable injury claim, report the same to their insurer.

(2) If a worker is injured and requires only first aid without medical services and is otherwise not entitled to compensation, no notice need be given the insurer where the employer maintains records of the date, worker and nature of injury treated for at least one year, which records shall be open to inspection by the Director or any party or its representative. For the purpose of this section, "medical services" means any medical treatment which is normally provided for an injury by a licensed individual, regardless of who provides it, or where it is provided.

(3) An employer who is delinquent in reporting claims to its insurer in excess of 10 percent of their total claims reported during any quarter may receive a penalty assessed by the Director.

(4) An employer who intentionally or repeatedly makes payment of compensation in lieu of reporting to its insurer any claim or accident which may result in a compensable injury claim may receive a penalty assessed by the Director.

(5) The insurer shall receive, process and file a claim in compliance with ORS Chapter 656 to include reports as required in Chapter 656, WCD Administrative Orders and WCD Bulletins. A "First Medical Report" Form 827, signed by the worker, is considered written notice of an accident which may involve a compensable injury in accordance with ORS 656.265. As such, the signed Form 827 shall start the claim process the same as the Form 801, but shall not relieve the worker or employer of the responsibility of filing Form 801.

(6) Any insurer who is delinquent in reporting or who submits the Forms 801, 1502, 1503 or 1644 with a late or error ratio of 10 percent of the volume of each respective form during any quarter may receive a penalty assessed by the Director.

Hist: Filed 1/11/80 as WCD Admin. Order 1-1980, eff. 1/11/80
Amended 12/23/81 as WCD Admin. Order 6-1981, eff. 1/1/82
Amended 12/29/83 as WCD Admin. Order 8-1983, eff. 1/1/84
Renumbered from 436-54-100, May 1, 1985
Amended 12/12/85 as WCD Admin. Order 8-1985, eff. 1/1/86
Amended 12/18/87 as WCD Admin. Order 4-1987, eff. 1/1/88

NOTICE TO WORKER'S ATTORNEY

436-60-015 (1) When an injured worker is represented by an attorney and the attorney has given written notice of such representation:

(a) The Director or insurer shall not request the worker to submit to an independent medical examination without giving prior or simultaneous written notice to the worker's attorney.

(b) The insurer shall not request suspension of compensation pursuant to ORS 656.325 without giving prior or simultaneous written notice to the worker's attorney.

(c) An insurer shall not contact the worker without giving prior or simultaneous written notice to the worker's attorney if the contact affects the denial, reduction or termination of the worker's benefits.

(2) An insurer who intentionally or repeatedly fails to give prior or simultaneous written notice to the worker's attorney as required by section (1) may receive a penalty assessed by the Director.

Hist: Filed 12/12/85 as WCD Admin. Order 8-1985, eff. 1/1/86

PAYMENT OF TEMPORARY TOTAL DISABILITY COMPENSATION

436-60-020 (1) Payment of compensation under ORS 656.262(4) may be made by the subject employer if the employer so chooses. The making of such payments does not constitute a waiver or transfer of the insurer's duty to determine entitlement to benefits or responsibility to ensure timely benefit payments. The employer shall provide its insurer with adequate payment documentation, as the insurer may require, to meet these responsibilities.

(2) No compensation is due for temporary total disability suffered during the first three calendar days after the worker leaves work as a result of a

compensable injury, unless the total disability is continuous for a period of 14 days or the worker is an inpatient in a hospital within the first period of time loss. The three day waiting period is three consecutive calendar days beginning with the day the worker first loses time from work as a result of the compensable injury. If the worker leaves work but returns and completes the work shift, that day shall not be considered the first day of the three day waiting period. If the worker leaves work and does not complete the work shift, that day shall be considered the first day of the three day waiting period even though the worker may return to the next scheduled work shift. The three day waiting period applies to temporary partial disability pursuant to ORS 656.212 the same as it does for temporary total disability.

(3) Until such time as the worker is determined to be medically stationary, when a worker with an accepted disabling compensable injury is required to leave work for any single period of four hours or more to receive medical consultation, examination or treatment with regard to the compensable injury, the worker shall receive temporary disability benefits calculated pursuant to ORS 656.212 for the period during which the worker is absent. However, such benefits are not payable if wages are paid for the period of absence by the employer.

(4) When concurrent temporary disability is due the worker as a result of two or more separate claims, the insurers may petition Compliance to make a pro rata distribution of compensation due under ORS 656.210. The insurers shall not unilaterally prorate temporary disability without the approval of Compliance. Compliance may order one of the insurers to pay the entire amount of temporary disability due or it may make a pro rata distribution between two or more of the insurers.

(5) The rate of compensation for regularly employed workers shall be computed as outlined in ORS 656.210. Monthly wages shall be divided by 4.35 to determine weekly wages. Continued payment of wages by the employer shall not be made in lieu of statutory temporary total disability due. The employer, however, is not precluded from supplementing the amount of temporary total disability paid the worker. Any workers' compensation benefits shall be identified separate from other moneys paid by the employer and shall not have usual payroll deductions withheld from such benefits.

(6) The rate of compensation for workers employed with minimal earnings and entitled to the lesser amount of 90 percent of wages a week or the amount of $50.00 shall be computed as follows: Use 90 percent of weekly wages when worker's wages are $55.56 or less per week; Use $50.00 when worker's weekly wage falls between $55.56 and $75.00 per week; Use 66 2/3 percent of weekly wages when the worker's wages are $75.00 or more per week.

(7) The rate of compensation for workers employed with unscheduled, irregular or no earnings shall be computed on the wages determined by this section. Situations not covered by ORS 656.210 or this section shall be resolved by the insurer contacting the employer and worker to determine a reasonable wage to coincide with the objectives of the Workers' Compensation Law.

(a) Employed on call basis: Use average weekly earnings for past 26 weeks, if available, unless periods of extended gaps exist, then use no less than last 4 weeks of employment to arrive at average. For workers employed less than 4 weeks, or where extended gaps exist within the 4 weeks, use intent at time of hire as confirmed by employer and worker.

(b) Employed Piecework: Use average as in subsection (a).

(c) Employed varying hours, shifts or wages: Use average as in subsection (a).

(d) Employed through union hall call board: Compute as 5 day worker regardless of number of days actually worked per week.

(e) Employed salary plus considerations (rent, utilities, food, etc.): Use only salary if considerations continue; use salary plus reasonable value of considerations if lost.

(f) Employed two jobs, two employers: Use only wage of job on which injury occurred if worker unable to work either job. If able to return to job where injury occurred, no benefit is due. If able to return to the job other than the one where injury occurred, temporary partial disability is due based on the combined earning power of both jobs.

(g) Employed where tips are a part of earnings: Use regular wages actually received, plus amount of tips required to be reported by the employer pursuant to section 6053 of the Internal Revenue Code of 1954, as amended, or the amount of actual tips reported by the worker, whichever amount is greater. Tips include tips the worker receives directly from customers, tips from charge customers that are paid to the worker by the employer, and the worker's share of any tips the worker receives under a tip-splitting arrangement.

(h) Employed 1 or 2 days per week: Use daily wage times 3 to arrive at weekly wage (ORS 656.210).

(i) Employed with overtime: Overtime shall be considered only when worked on a regular basis. Overtime earnings shall be considered at the overtime rate rather than straight time. Example: If one day of overtime per month for a normally 40 hour a week worker, use 40 hours at regular wage and 2 hours at overtime wage; etc., to compute the weekly rate. If overtime varies in hours worked per day or week, use average as in subsection (a). One-half day or more will be considered a full day when determining days worked per week.

(j) Employed with incentive pay: Incentive pay provided by contract of employment shall be considered only when regularly earned. If incentive pay earnings vary, use average as in subsection (a).

(k) Employed with no wage earnings: Volunteer workers, city and county jail inmates, etc., when covered, shall have their benefits computed on the same assumed wage as premium is based.

(l) Employed commission only; commission plus wages: Use average commission earnings for past 26 weeks, if available. For workers without 26 weeks of earnings use the assumed wage on which premium is based. Any regular wage in addition to commission shall be included in the wage.

(m) Sole proprietors, partners and officers of corporation: Use assumed wage on which premium is based.

(n) School teachers or workers paid in like manner: Use annual salary divided by 52 weeks to arrive at weekly wage. Statutory temporary disability benefits shall extend over the calendar year.

(8) When payable, compensation for the initial work day lost shall be paid for 1/2 day if the worker leaves the job during the first half of the shift and no compensation for the initial work day lost if the worker leaves the job during the second half of the shift.

(9) When a working shift extends into another calendar day, the date of injury shall be the date used for payroll purposes by the employer.

Hist: Filed 9/21/70 as WCB Admin. Order 12-1970
Amended 1/11/80 as WCD Admin. Order 1-1980, eff. 1/11/80
Amended 12/23/81 as WCD Admin. Order 6-1981, eff. 1/1/82
Amended 12/29/83 as WCD Admin. Order 8-1983, eff. 1/1/84
Renumbered from 436-54-212, May 1, 1985
Amended 12/12/85 as WCD Admin. Order 8-1985, eff. 1/1/86
Amended 12/18/87 as WCD Admin. Order 4-1987, eff. 1/1/88

PAYMENT OF TEMPORARY PARTIAL DISABILITY COMPENSATION

436-60-030 (1) The rate of temporary partial disability compensation due a worker shall be determined by:

(a) subtracting the post-injury wage earnings available from any kind of work; from

(b) the wage earnings from the employment at the time of, and giving rise to, the injury; then

(c) dividing the difference by the wage earnings in subsection (b) to arrive at the percentage of loss of earning power; then

(d) multiplying the current temporary total disability compensation rate by the percentage of loss of earning power.

(2) If the post-injury wage earnings are equal to or greater than the wage earnings at the time of injury, no temporary disability compensation is due.

(3) An insurer shall cease paying temporary total disability compensation and commence making payment of such temporary partial disability compensation as is due from the date an injured worker accepts and commences any kind of wage earning employment prior to claim determination.

(4) Temporary partial disability compensation payable pursuant to section (3) shall continue to be paid until:

(a) the attending physician verifies that the worker cannot continue working and is again temporarily totally disabled;

(b) the compensation is terminated by order of the Department or by claim closure by the insurer pursuant to ORS 656.268; or

(c) the compensation has been paid for two years.

(5) An insurer shall cease paying temporary total disability compensation and start making payment of such temporary partial disability compensation as would be due in section (1) when an injured worker refuses wage earning employment prior to claim determination under the following conditions:

(a) the attending physician has been notified by the employer or insurer of the specific duties to be performed by the injured worker and the physical requirements thereof;

(b) the attending physician agrees that the offered employment appears to be within the worker's capabilities; and

(c) the employer has provided the injured worker with a written offer of the employment which states the beginning time, date and place; the duration of the job, if known; the wage rate payable; an accurate description of the job duties and that the attending physician has said the offered employment appears to be within the worker's capabilities.

(6) Temporary partial disability compensation payable pursuant to section (5) shall continue to be paid until:

(a) the attending physician verifies that the worker's condition is such that he could no longer perform such work and is again temporarily totally disabled;

(b) 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;

(c) the compensation is terminated by order of the Department or by claim closure of the insurer pursuant to ORS 656.268; or

(d) the compensation has been paid for two years.

(7) An insurer shall provide a written explanation to the injured worker, and the worker's attorney if represented, 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 Compliance in cases where the worker has refused wage earning employment.

Hist: Filed 4/27/78 as WCD Admin. Order 6-1978, eff. 4/27/80
Amended 1/11/80 as WCD Admin Order 1-1980, eff. 1/11/80
Amended 12/23/81 as WCD Admin. Order 6-1981, eff. 1/1/82
Amended 12/29/83 as WCD Admin. Order 8-1983, eff. 1/1/84
Renumbered from 436-54-222, May 1, 1985
Amended 12/12/85 as WCD Admin. Order 8-1985, eff. 1/1/86
Amended 12/18/87 as WCD Admin. Order 4-1987, eff. 1/1/88

PAYMENT OF PERMANENT PARTIAL DISABILITY COMPENSATION

436-60-040 (1) The worker may receive both permanent partial disability and temporary total disability at the same time. When a claim is reopened as a result of an aggravation of the worker's condition and temporary total disability is due, any permanent partial disability benefits due shall continue to be paid concurrently with temporary total disability benefits.

(2) When training commences in accordance with OAR 436-120 after the issuance of a determination order, Opinion and Order of a Referee, Order on Review, or Mandate of the Court of Appeals, the insurer shall suspend any award payments due under the order or mandate and pay time loss.

(3) Upon completion or ending of the training, unless the worker then is not medically stationary, the insurer shall stop temporary disability compensation payments and resume any suspended award payments. If no award payment remains due, temporary disability shall continue pending a subsequent determination order by Evaluation, unless the worker has returned to regular employment. If the worker has returned to work, the insurer may reevaluate and close the claim without the issuance of a determination order by Evaluation.

Hist: Filed 12/23/81 as WCD Admin. Order 6-1981, eff. 1/1/82
Amended 12/29/83 as WCD Admin. Order 8-1983, eff. 1/1/84
Renumbered from 436-54-232, May 1, 1985
Amended 12/12/85 as WCD Admin. Order 8-1985, eff. 1/1/86
Amended 12/18/87 as WCD Admin. Order 4-1987, eff. 1/1/88

PAYMENT OF MEDICAL SERVICES; CHOICE OF ATTENDING PHYSICIAN

436-60-050 (1) Except as provided by OAR 436-60-055, only the insurer shall pay for medical services relating to a compensable injury claim. Such services include, but are not limited to, medical, surgical, hospital, nursing, ambulances, and other related services, and drugs, medicine, crutches and prosthetic appliances, braces and supports and where necessary, physical restorative services.

(2) For the purpose of this rule, a prosthetic appliance is an artificial substitute for a missing part or any device by which performance of a natural function is aided or augmented, including, but not limited to, hearing aids or eye glasses. If such a prosthetic appliance is damaged when in use at the time of a compensable injury the cost is a compensable medical expense, regardless of whether the worker actually received a physical injury at the time of the compensable injury.

(3) Any claim for medical services referred to under ORS 656.245 or this rule shall be submitted to the insurer even after aggravation rights under ORS 656.273 have expired. If the claim for medical services is denied, the worker may submit a request for hearing pursuant to ORS 656.283.

(4) The worker may choose an attending physician within the state of Oregon. Reimbursement to the worker of transportation costs to visit the attending physician, however, may be limited to within a city, or metropolitan area, or the distance to the nearest city or metropolitan area, from where the worker resides and where a physician providing like services is available. A worker who relocates within the state of Oregon may continue treating with the attending physician and be reimbursed transportation costs accordingly. If an insurer chooses to limit reimbursement to the nearest available city, or metropolitan area, a written explanation shall be provided the worker along with a list of physicians who provide the like services within an acceptable distance of the worker. The worker shall be made aware of the fact treatment may continue with any attending physician within the state of Oregon of the worker's choice, but the reimbursement of transportation costs will be limited as described.

(5) When the worker chooses an attending physician outside the state of Oregon, the insurer may object to the worker's choice and select the attending physician. Payment for treatment or services rendered to the worker after the insurer has objected to the worker's choice of attending physician may be rejected by the insurer.

Hist: Filed 12/23/81 as WCD Admin. Order 6-1981, eff. 1/1/82
Amended 12/29/83 as WCD Admin. Order 8-1983, eff. 1/1/84
Renumbered from 436-54-245, May 1, 1985
Amended 12/12/85 as WCD Admin. Order 8-1985, eff. 1/1/86
Amended 12/18/87 as WCD Admin. Order 4-1987, eff. 1/1/88

LUMP SUM PAYMENT OF PERMANENT PARTIAL DISABILITY AWARDS

436-60-060 (1) A lump sum payment of any award must be approved by Compliance when an award for permanent partial disability exceeds 64 degrees. Such required approval extends to situations where the value of the award, through periodic payments or offset, is reduced to below the 64 degree value. Subsequent awards below the 64 degree value shall be paid by the insurer in the same manner as provided by ORS 656.230(2). Any lump sum payment of a permanent partial disability award ordered as a result of litigation does not require Compliance approval.

(2) For injuries occurring prior to August 9, 1983, Compliance hereby authorizes the insurer, in its discretion, to make a lump sum payment of a permanent partial disability award not in excess of 64 degrees provided the worker is not asked to waive any appeal rights. For injuries occurring on or after August 9, 1983, and the award does not exceed 64 degrees, the insurer shall pay all of the award to the worker in a lump sum.

(3) In cases where the final payment would be less than the amount computed in accordance with ORS 656.216(1), the insurer may include the lesser amount with the last full monthly payment of the award to the worker without Compliance approval.

(4) A worker who has been awarded a permanent partial disability award in excess of 64 degrees may apply to Compliance, through the insurer, for an order directing the paying agent to pay all or part of the unpaid award in a lump sum. Any lump sum award will be subject to the law in force at the time of injury.

(5) The application shall include but not be limited to:

(a) a description of the award amount, amount of the monthly payments being paid, payments already paid, balance remaining and amount of award requested;

(b) original signatures of both the worker and the insurer; and

(c) in prominent or bold-face type the paragraph:

"I UNDERSTAND THAT BY APPLYING FOR AND ACCEPTING A LUMP SUM PAYMENT OF ALL OR ANY PART OF MY PERMANENT PARTIAL DISABILITY AWARD, I WAIVE THE RIGHT TO APPEAL THE ADEQUACY OF THE AWARD."

(6) Compliance, in considering an application will not approve a lump sum payment when:

(a) the worker is engaged in a vocational assistance training program;

(b) the worker is receiving vocational assistance or is temporarily withdrawn from a training program; or

(c) the worker is engaged in litigation affecting the worker's permanent partial disability award.

(7) Compliance shall approve or deny an application for lump sum payment of an award within 30 days after receipt of the application, unless additional information is needed to make a decision. Compliance may approve an application to pay all or part of the award, as requested, or it may approve a lump sum payment of less than requested, or it may deny an application.

(8) If Compliance approves an application, as submitted or as revised, it shall order the paying agency to pay the award in a lump sum in the amount approved within 5 working days after receipt of the order. Copies of the order and application approving or denying the application shall be sent to the paying agent and the applicant.

(9) If the application is denied in whole or in part by Compliance, the worker shall be informed that within 15 days of the date of the order, the Director may be petitioned to reconsider the application.

(10) The Director shall, within 20 days after receipt of the petition,

examine the application and such further evidence filed and enter an order. Copies of the order shall be sent to the paying agent, applicant and Compliance. Granting or denying a lump sum is at the sole discretion of the Director. Any such order issued by the Director is not appealable.

(11) If a lump sum payment is approved for part of an award, the lump sum payment shall be in addition to the regularly scheduled monthly payment. The remaining balance shall be paid pursuant to ORS 656.216.

(12) Denial or approval of an application does not prevent another application by the worker for a lump sum payment of all or part of any remainder of the award, provided additional justification is submitted.

(13) Nothing in this rule applies to any lump sum payment included in a compromise settlement of a case that is pending before the Hearings Division of the Board.

Hist: Filed 6/23/66 as WCB Admin. Order 6-1966
Amended 2/13/74 as WCB Admin. Order 5-1974, eff. 3/11/74
Amended 1/11/80 as WCD Admin. Order 1-1980, eff. 1/11/80
Amended 12/23/81 as WCD Admin. Order 6-1981, eff. 1/1/82
Amended 12/29/83 as WCD Admin. Order 8-1983, eff. 1/1/84
Renumbered from 436-54-250, May 1, 1985
Amended 12/12/85 as WCD Admin. Order 8-1985, eff. 1/1/86
Amended 12/18/87 as WCD Admin. Order 4-1987, eff. 1/1/88

REIMBURSEMENT OF RELATED SERVICES COST TO A WORKER

436-60-070 (1) The worker shall be notified at the time of claim acceptance that travel, prescriptions and other compensable injury related services paid by the worker will be reimbursed by the insurer upon request.

(2) For the purpose of this rule:

(a) The actual reasonable cost to a worker of related services resulting from a compensable injury shall be reimbursed within 60 days of the date of receipt by the insurer of a written request. The request shall be accompanied by sales slips, receipts or other evidence necessary to support the request.

(b) Meals, lodging, public transportation or use of a private vehicle required to seek medical services or collect compensation benefits when reimbursed at the then applicable rate of reimbursement to State of Oregon classified employes shall be deemed in compliance with this section. Child care benefits when reimbursed at the then applicable rate as prescribed by the Department of Human Resources, Children Services Division of the State of Oregon shall be deemed in compliance with this section. Reimbursement in excess of these rates will be allowed in those cases where special transportation, lodging or child care is necessary and required.

(3) Requests for reimbursement of services not claim-related shall be returned to the injured worker within 60 days of the date of receipt by the insurer with an explanation of the reason for nonpayment.

Hist: Filed 10/23/69 as WCB Admin. Order 6-1969, eff. 10/29/69
Amended 1/11/80 as WCD Admin. Order 1-1980, eff. 1/11/80
Amended 12/23/81 as WCD Admin. Order 6-1981, eff. 1/1/82
Amended 12/29/83 as WCD Admin. Order 8-1983, eff. 1/1/84
Renumbered from 436-54-270, May 1, 1985
Amended 12/12/85 as WCD Admin. Order 8-1985, eff. 1/1/86
Amended 12/18/87 as WCD Admin. Order 4-1987, eff. 1/1/88

CONSENT TO SUSPENSION OF COMPENSATION OR REDUCTION OF BENEFITS AWARDED THE WORKER

436-60-080 (1) Compliance is responsible for issuing an order of consent to the suspension of compensation by an insurer under the following conditions:

(a) An order shall be issued if the worker, when requested by the Director or insurer, fails or refuses to submit to medical examination, or obstructs the same, at a time and from time to time at a place reasonably convenient for the worker. The compensation under the order shall be suspended until the examination has taken place. No compensation shall be due or paid during such period.

(b) An order shall be issued for any period of time during which a worker fails or refuses to participate in a physical rehabilitation program. No compensation shall be due or paid during such period.

(c) An order shall be issued for any period of time during which a worker commits any insanitary or injurious practice which tends to either imperil or retard recovery. No compensation shall be due or paid during such period.

(d) An order shall be issued for any period of time during which a worker refuses to submit to such medical or surgical treatment as is reasonably essential to promote recovery. No compensation shall be due or paid during such period.

(2) The worker shall be provided the opportunity to dispute the matter of suspension of compensation prior to the issuance of an order by Compliance.

(3) Compliance may modify or set aside any order of consent to the suspension of compensation authorized before or after a request for hearing is filed.

(4) Compliance has the authority to order payment of compensation, previously authorized suspended, in cases where incorrect information was provided at the time suspension occurred.

(5) Compliance shall notify all interested parties of any order authorizing suspension, any modification of such order or the setting aside of such order.

(6) Compliance may modify the period of suspension of compensation or deny a request for suspension of compensation because of an improper request.

(7) Continued payment of compensation to a worker, when an order of consent has been issued, shall not constitute failure to comply with this section on the part of the insurer, however, such continued payment shall not be recovered at a later date as an overpayment.

(8) Evaluation may reduce, upon petition by the employer of the injured worker, the insurer or upon instructions by the Director, any benefits awarded the worker pursuant to ORS 656.268 when the worker has, without a valid reason, failed to follow medical advice of the attending physician or has failed to participate in or complete physical rehabilitation or vocational assistance programs prescribed for the worker pursuant to ORS Chapter 656 and WCD Administrative Rules. The benefits may be reduced by the amount the disability has been increased by the worker's failure to follow medical advice of the attending physician or to participate in or complete physical rehabilitation or vocational assistance programs.

Hist: Filed 12/11/70 as WCB Admin. Order 16-1970
Amended 4/27/78 as WCD Admin. Order 6-1978, eff. 4/27/78
Amended 1/11/80 as WCD Admin. Order 1-1980, eff. 1/11/80
Amended 12/13/81 as WCD Admin. Order 6-1981, eff. 1/1/82
Amended 12/29/83 as WCD Admin. Order 8-1983, eff. 1/1/84
Renumbered from 436-54-280, May 1, 1985
Amended 12/12/85 as WCD Admin. Order 8-1985, eff. 1/1/86
Amended 12/18/87 as WCD Admin. Order 4-1987, eff. 1/1/88

REQUEST FOR CONSENT TO SUSPENSION OF COMPENSATION; WORKER'S FAILURE OR REFUSAL TO SUBMIT TO MEDICAL EXAMINATION

436-60-090 (1) A worker shall submit to medical examination at a time and, from time to time, at a place reasonably convenient for the worker when requested to do so by the Director or insurer. However, no more than three separate medical examinations at different times, may be requested during the life of the claim, except after notification to and authorization by the Director pursuant to OAR 436-10.

(2) If an issue to be clarified by the scheduled examination is the necessity of continued treatment in the recovery process, and the worker fails or refuses to be examined, further treatment can be suspended by order of Compliance pending cooperation by the worker.

(3) The Director or insurer shall notify the worker, and the worker's attorney if represented, in writing at least 10 days prior to the examination to ensure receipt of the notice of the following:

(a) name of the examining physician or facility;

(b) the purpose of the examination;

(c) the date, time and place of the examination;

(d) the attending physician was notified of the examination;

(e) when required, the medical director has approved the examination;

(f) that the reasonable cost of public transportation or use of a private vehicle will be reimbursed and, that when necessary, reasonable cost of child care, meals, lodging and other related services will be reimbursed. A request for reimbursement must be accompanied by a sales slip, receipt or other evidence necessary to support the request. Should an advance of these costs be necessary for attendance, a request for advancement shall be made in sufficient time to ensure a timely appearance; and

(g) in prominent or bold-face type the paragraph:

"ATTENDANCE OF THIS EXAMINATION IS MANDATORY. YOU ARE RESPONSIBLE FOR NOTIFYING US PRIOR TO THE DATE OF THE EXAMINATION OF ANY REASON WHY YOU CANNOT ATTEND AS SCHEDULED. FAILURE TO ATTEND THIS EXAMINATION, OR COOPERATE IN THE EXAMINATION, OR AN INVALID REASON FOR NOT ATTENDING SHALL RESULT IN SUSPENSION OF YOUR COMPENSATION BENEFITS PURSUANT TO ORS 656.325 and OAR 436-60."

(4) The Director or insurer upon receipt from the worker of a valid reason for not attending a scheduled examination or not completing an authorized program shall determine whether to reschedule same. If the examination is to be rescheduled, the Department or insurer shall immediately reschedule the worker for the requested examination as soon as possible in the future and consistent with the ability of the worker to submit to such examination.

(5) The Director or insurer shall verify by direct telephone communication with the examining physician, facility or with the staff of such physician or of such facility on the day scheduled for the examination that the worker did submit to the examination or that the worker failed to submit to examination.

(6) The insurer requesting consent to suspension of compensation because of a worker's failure or refusal to submit to a medical examination, or obstruction of same, shall apply to Compliance. A copy of the application request shall be delivered to the worker at the last known address by registered or certified mail with return receipt requested or by personal service meeting the requirements for service of a summons, and to the worker's attorney if represented. The application in letter form shall contain the following information:

(a) consent for suspension of compensation is requested pursuant to ORS 656.325 and OAR 436-60;

(b) what the worker was requested to submit to;

(c) the dates of all prior examinations scheduled by the insurer and the physician seen. If none, so state. If medical director's approval was obtained, provide a copy of the approval. If the current examination is by a consulting physician, written documentation of the physician's referral must be provided;

(d) that the worker failed or refused to be examined and any reason given by the worker why the examination could not be attended as scheduled. If a reason was provided but is considered invalid, explain;

(e) the date that verification of failure to attend was obtained from the examining physician, facility or their staff. Any delay in obtaining verification or in requesting consent for suspension of compensation may result in authorization being denied or the date of authorization be modified by the date of actual verification or the date the request is received by Compliance;

(f) whether an examination will be rescheduled and, if so, the date, time and place of any rescheduled examination;

(g) any pertinent information that supports the request for suspension of compensation; and

(h) in prominent or bold-faced type the paragraph:

"NOTICE TO WORKER: IF YOU THINK THIS APPLICATION FOR SUSPENSION OF COMPENSATION IS NOT RIGHT YOU MAY RESPOND IN WRITING TO THE COMPLIANCE SECTION, WORKERS' COMPENSATION DIVISION, DEPARTMENT OF INSURANCE AND FINANCE, LABOR & INDUSTRIES BUILDING, SALEM, OREGON 97310. YOUR RESPONSE MUST BE RECEIVED BY THE DEPARTMENT WITHIN 10 WORKING DAYS OF THE DATE OF THIS NOTICE."

(7) The application to Compliance shall be accompanied by a copy of the letter required in section (3) sent to the worker.

(8) Compliance shall consider all documentation and correspondence submitted by the insurer and worker. If the evidence supports the application, Compliance shall issue an order consenting to the suspension of compensation by the insurer from a date prescribed in subsection (6)(e) of this rule and until such time as the worker has submitted to an examination scheduled by the Director or insurer.

(9) The Compliance order consenting to the suspension of compensation by an insurer shall contain a notice, in prominent or bold-face type, as follows:

"IF YOU THINK THIS ORDER IS NOT RIGHT YOU MAY REQUEST A RECONSIDERATION OR A HEARING. REQUEST FOR RECONSIDERATION MUST BE IN WRITING AND SENT TO THE COMPLIANCE SECTION, WORKERS' COMPENSATION DIVISION, DEPARTMENT OF INSURANCE AND FINANCE, LABOR & INDUSTRIES BLDG., SALEM, OR 97310. HEARING REQUESTS MUST BE SENT TO THE HEARINGS DIVISION, WORKERS' COMPENSATION BOARD, 480 CHURCH STREET SE, SALEM, OR 97310."

(10) The Director or insurer shall verify when the worker has submitted to the rescheduled examination and shall immediately notify Compliance, by letter, of the worker's attendance and that compensation has resumed as of the date of the examination.

(11) The insurer may request an administrative order of closure be issued by Evaluation if the worker has made no effort to have compensation reinstated within 60 days after Compliance has authorized suspension of compensation.

Hist: Filed 12/11/70 as WCB Admin. Order 16-1970
Amended 4/27/78 as WCD Admin. Order 6-1978, eff. 4/27/78
Amended 1/11/80 as WCD Admin. Order 1-1980, eff. 1/11/80
Amended 12/23/81 as WCD Admin. Order 6-1981, eff. 1/1/82
Amended 12/29/83 as WCD Admin. Order 8-1983, eff. 1/1/84
Renumbered from 436-54-283, May 1, 1985
Amended 12/12/85 as WCD Admin. Order 8-1985, eff. 1/1/86
Amended 12/18/87 as WCD Admin. Order 4-1987, eff. 1/1/88

REQUEST FOR CONSENT TO SUSPENSION OF COMPENSATION; WORKER'S FAILURE TO PARTICIPATE IN A PHYSICAL REHABILITATION PROGRAM

436-60-100 (1) A worker is required to participate in a physical rehabilitation program. A notice of such program issued by an insurer shall include a notice as described in section (2) informing the worker that failure to participate in the program shall result in suspension of compensation.

(2) The Director or insurer shall notify the worker, and the worker's attorney if represented, in writing at least 10 days prior to the start of a program of physical rehabilitation to ensure receipt of the notice of the following:

(a) purpose of the program;

(b) the date, time and place of the program;

(c) the attending physician was notified of the program;

(d) that the reasonable cost of public transportation or use of a private vehicle will be reimbursed and, that when necessary, reasonable cost of child care, meals, lodging and other related services will be reimbursed. A request for reimbursement must be accompanied by a sales slip, receipt or other evidence necessary to support the request. Should an advance of these costs be necessary for attendance, a request for advancement shall be made in sufficient time to ensure a timely appearance; and

(e) in prominent or bold-face type the paragraph:

"ATTENDANCE AND PARTICIPATION IS REQUIRED IN A PROGRAM OF PHYSICAL REHABILITATION. FAILURE TO PARTICIPATE SHALL RESULT IN SUSPENSION OF YOUR COMPENSATION BENEFITS AND POSSIBLE REDUCTION OF ANY PERMANENT DISABILITY AWARDED PURSUANT TO ORS 656.325 and OAR 436-60."

(3) The Director or insurer upon receipt from the worker of a valid reason for not participating in a physical rehabilitation program shall determine whether to reschedule or continue same. If the program is to be rescheduled it shall be rescheduled as soon as possible in the future and consistent with the ability of the worker to participate in the program.

(4) The notice in section (2) will not be required to be repeated once the worker has agreed to participate in a physical rehabilitation program and then elects to withdraw after the specified date.

(5) The insurer requesting consent to suspension of compensation because of a worker's failure or refusal to participate in a program of physical rehabilitation, or obstruction of same, shall apply to Compliance. A copy of the application request shall be delivered to the worker at the last known address by registered or certified mail with return receipt requested or by personal service meeting the requirements for service of a summons, and to the worker's attorney if represented. The application in letter form shall contain the following information:

(a) consent for suspension of compensation is requested pursuant to ORS 656.325 and OAR 436-60;

(b) what actions of the worker initiated the request for suspension of compensation;

(c) any reason given by the worker for failure or refusal to participate in the program, or obstruction of same;

(d) the date that failure by the worker to participate in a physical rehabilitation program was verified and with whom or how verified. Such verification is required to be made immediately and any delay can result in suspension of compensation not being authorized until the actual date of verification, the date the request is received by Compliance, or not at all;

(e) whether the program will be rescheduled and, if so, the date and place;

(f) any pertinent information that supports the request for suspension of compensation; and

(g) a notice, in prominent or bold-faced type, as follows:

"NOTICE TO WORKER: IF YOU THINK THIS APPLICATION FOR SUSPENSION OF COMPENSATION IS NOT RIGHT, YOU MAY RESPOND IN WRITING TO THE COMPLIANCE SECTION, WORKERS' COMPENSATION DIVISION, DEPARTMENT OF INSURANCE AND FINANCE, LABOR & INDUSTRIES BUILDING, SALEM, OREGON 97310. YOUR RESPONSE MUST BE RECEIVED BY THE DEPARTMENT WITHIN 10 WORKING DAYS OF THE DATE OF THIS NOTICE."

(6) The application to Compliance shall be accompanied by a copy of the letter required in section (2) sent to the worker.

(7) Compliance shall consider all documentation and correspondence submitted by the insurer and worker. If the evidence supports the application, Compliance shall issue an order consenting to suspension of compensation by the insurer from a date prescribed in subsection (5)(d) of this rule and until such time as the worker participates in a program or such program is determined inappropriate.

(8) The Compliance order consenting to the suspension of compensation by an insurer shall contain a notice, in prominent or bold-face type, as follows:

"IF YOU THINK THIS ORDER IS NOT RIGHT YOU MAY REQUEST A RECONSIDERATION OR A HEARING. REQUEST FOR RECONSIDERATION MUST BE IN WRITING AND SENT TO THE COMPLIANCE SECTION, WORKERS' COMPENSATION DIVISION, DEPARTMENT OF INSURANCE AND FINANCE, LABOR & INDUSTRIES BLDG., SALEM, OR 97310. HEARINGS REQUESTS MUST BE SENT TO THE HEARINGS DIVISION, WORKERS' COMPENSATION BOARD, 480 CHURCH STREET SE, SALEM, OR 97310."

(9) The insurer shall notify Compliance by letter when the worker participates in a program, and that compensation has resumed.

(10) The insurer may request an administrative order of closure be issued by Evaluation if the worker has made no effort to have compensation reinstated within 60 days after the authorization of consent to the suspension of compensation.

Hist: Filed 12/23/81 as WCD Admin. Order 6-1981, eff. 1/1/82
Amended 12/29/83 as WCD Admin. Order 8-1983, eff. 1/1/84
Renumbered from 436-54-284, May 1, 1985
Amended 12/12/85 as WCD Admin. Order 8-1985, eff. 1/1/86
Amended 12/18/87 as WCD Admin. Order 4-1987, eff. 1/1/88

REQUEST FOR CONSENT TO SUSPENSION OF COMPENSATION; WORKER'S COMMISSION OF INSANITARY OR INJURIOUS PRACTICES

436-60-110 (1) The insurer shall upon knowledge of a worker committing insanitary or injurious practices which tends to either imperil or retard recovery request in writing to the worker that such practices stop. The letter to the worker with copy to the worker's attorney if represented, shall explain:

(a) the insanitary or injurious practices being committed;

(b) that such practices are considered insanitary or injurious by the attending physician;

(c) that such practices stop by a specified date in the reasonable future and remain stopped; and

(d) in prominent or bold-face type the paragraph:

"COMMITTING OF SUCH INSANITARY OR INJURIOUS PRACTICES BEYOND THE DATE INDICATED SHALL RESULT IN SUSPENSION OF COMPENSATION BENEFITS AND POSSIBLE REDUCTION OF ANY PERMANENT DISABILITY AWARDED PURSUANT TO ORS 656.325 AND OAR 436-60."

(2) The insurer shall verify on the specified date whether the worker did or did not stop the insanitary or injurious practices and, if stopped, periodically check to see that such practices remain stopped.

(3) The insurer will not be required to repeat the request in section (1) once the injured worker has been put on notice and again commits the same insanitary or injurious practices after the specified date.

(4) The insurer requesting consent to suspension of compensation because of a worker's failure to stop insanitary or injurious practices, shall apply to Compliance. A copy of the application request shall be delivered to the worker at the last known address by registered or certified mail with return receipt requested or by personal service meeting the requirements for service of a summons, and to the worker's attorney if represented. The application in letter form shall contain the following information:

(a) consent for suspension of compensation is requested pursuant to ORS 656.325 and OAR 436-60;

(b) explanation of the insanitary or injurious practice being committed by the worker;

(c) whether or not the attending physician considers the practices to be insanitary or injurious to the worker;

(d) that the worker continues the insanitary or injurious practices after the date specified in the letter to the worker;

(e) the date that failure by the worker to stop the practices was verified and with whom or how verified. Any delay in obtaining verification or in requesting consent for suspension of compensation may result in authorization being denied or the date of authorization being modified by the date of actual verification or the date the request is received by Compliance;

(f) any pertinent information that supports the request for suspension of compensation; and

(g) in prominent or bold-faced type the paragraph:

"NOTICE TO WORKER: IF YOU THINK THIS APPLICATION FOR SUSPENSION OF COMPENSATION IS NOT RIGHT, YOU MAY RESPOND IN WRITING TO THE COMPLIANCE SECTION, WORKERS' COMPENSATION DIVISION, DEPARTMENT OF INSURANCE AND FINANCE, LABOR & INDUSTRIES BUILDING, SALEM, OREGON 97310. YOUR RESPONSE MUST BE RECEIVED BY THE DEPARTMENT WITHIN 10 WORKING DAYS OF THE DATE OF THIS NOTICE."

(5) The application to Compliance shall be accompanied by a copy of the letter required in section (1) sent to the worker.

(6) Compliance shall consult with the Medical Director to review whether the practices are insanitary or injurious to the worker's recovery.

(7) Compliance shall issue an order consenting to the suspension of compensation by an insurer for any period of time during which a worker commits any insanitary or injurious practice which tends to either imperil or retard recovery. The consent to suspension of compensation shall continue until the date the worker has, in fact, demonstrated termination of such practices to the insurer and no compensation shall be due or paid during such period.

(8) The Compliance order consenting to the suspension of compensation by an insurer shall contain a notice, in prominent or bold-face type, as follows:

"IF YOU THINK THIS ORDER IS NOT RIGHT YOU MAY REQUEST A RECONSIDERATION OR A HEARING. REQUEST FOR RECONSIDERATION MUST BE IN WRITING AND SENT TO THE COMPLIANCE SECTION, WORKERS' COMPENSATION DIVISION, DEPARTMENT OF INSURANCE AND FINANCE, LABOR & INDUSTRIES BLDG., SALEM, OR 97310. HEARING REQUESTS MUST BE SENT TO THE HEARINGS DIVISION, WORKERS' COMPENSATION BOARD, 480 CHURCH STREET SE, SALEM, OR 97310."

(9) The insurer shall continually monitor the claim to ascertain when the worker has, in fact, stopped committing the insanitary or injurious practices. When it is established that the practices have stopped, payment of compensation benefits shall commence effective on that date and the insurer shall immediately notify Compliance by letter of the date of resumption.

(10) The insurer may request an administrative order of closure be issued by Evaluation if the worker has made no effort to have compensation reinstated within 60 days after Compliance has authorized suspension of compensation.

Hist: Filed 12/11/70 as WCB Admin. Order 16-1970
Amended 4/27/78 as WCD Admin. Order 6-1978, eff. 4/27/78
Amended 1/11/80 as WCD Admin. Order 1-1980, eff. 1/11/80
Amended 12/23/81 as WCD Admin. Order 6-1981, eff. 1/1/82
Amended 12-29-83 as WCD Admin. Order 8-1983, eff. 1-1-84
Renumbered from 436-54-285, May 1, 1985
Amended 12/12/85 as WCD Admin. Order 8-1985, eff. 1/1/86
Amended 12/18/87 as WCD Admin. Order 4-1987, eff. 1/1/88

REQUEST FOR CONSENT TO SUSPENSION OF COMPENSATION; WORKER'S REFUSAL TO SUBMIT TO MEDICAL OR SURGICAL TREATMENT

436-60-120 (1) The insurer shall upon knowledge of worker refusing to submit to such medical or surgical treatment as is reasonably essential to promote recovery, request in writing to the worker that such treatment be obtained. The letter to the worker, with copy to the worker's attorney if represented, shall explain:

(a) the need for the recommended medical or surgical treatment;

(b) that such treatment is considered reasonably essential to promote the worker's recovery;

(c) that notice of consent for such treatment be given to the insurer by a specified date in the reasonable future; and

(d) in prominent or bold-face type the paragraph:

"THE DECISION WHETHER TO RECEIVE MEDICAL OR SURGICAL TREATMENT CONSIDERED REASONABLY ESSENTIAL TO PROMOTE RECOVERY IS A DECISION OF THE INJURED WORKER. FAILURE, HOWEVER, TO GIVE CONSENT BY THE DATE INDICATED OR FAILURE TO ACTUALLY RECEIVE SUCH TREATMENT SHALL RESULT IN SUSPENSION OF YOUR COMPENSATION BENEFITS AND POSSIBLE REDUCTION OF ANY PERMANENT DISABILITY AWARDED PURSUANT TO ORS 656.325 and OAR 436-60."

(2) For the purpose of this section failure of the worker to remain under a doctor's care, seek reasonable periodic examinations or participate in a treatment regimen shall be considered failure or refusal to submit to medical treatment.

(3) The insurer shall verify on the specified date whether the worker did or did not give consent for the recommended medical or surgical treatment.

(4) The insurer will not be required to repeat the request in section (1) once the injured worker has given consent for the recommended medical or surgical treatment and then elects to withdraw the consent after the specified date.

(5) The insurer requesting consent to suspension of compensation because of a worker's refusal to submit to recommended medical or surgical treatment, shall apply to Compliance. A copy of the application request shall be delivered to the worker at the last known address by registered or certified mail with return receipt requested or by personal service meeting the requirements for service of a summons, and to the worker's attorney if represented. The application in letter form shall contain the following information:

(a) consent for suspension of compensation is requested pursuant to ORS 656.325 and OAR 436-60;

(b) explanation of the recommended medical or surgical treatment;

(c) whether or not the attending physician considers the treatment reasonably essential to promote the worker's recovery;

(d) that the worker has refused and continues to refuse to submit to the recommended treatment after the date specified in the letter to the worker;

(e) any reason given by the worker for refusing to submit to the recommended medical or surgical treatment;

(f) the date that failure by the worker to give consent for the treatment was verified and with whom or how verified. Such verification is required to be made immediately and any delay can result in suspension of compensation not being authorized until the actual date of verification, the date the request is received by Compliance, or not at all; and

(g) in prominent or bold-faced type the paragraph:

"NOTICE TO WORKER: IF YOU THINK THIS APPLICATION FOR SUSPENSION OF COMPENSATION IS NOT RIGHT YOU MAY RESPOND IN WRITING TO THE COMPLIANCE SECTION, WORKERS' COMPENSATION DIVISION, DEPARTMENT OF INSURANCE AND FINANCE, LABOR & INDUSTRIES BUILDING, SALEM, OREGON 97310. YOUR RESPONSE MUST BE RECEIVED BY THE DEPARTMENT WITHIN 10 WORKING DAYS OF THE DATE OF THIS NOTICE."

(6) The insurer shall provide documentation to adequately demonstrate that the medical or surgical treatment is reasonably essential to promotion of the worker's recovery and that the need for such medical or surgical treatment has been fully explained to the worker by the physician recommending such treatment. Documentation should consist of doctor's reports, copies of correspondence, reports of consultation on the medical or surgical treatment recommended or any other written evidence which demonstrates the recommended treatment is reasonably essential.

(7) The application to Compliance shall be accompanied by a copy of the letter required in section (1) sent to the worker.

(8) Compliance shall consult with the Medical Director to review whether the recommended treatment is reasonably essential to promote the worker's recovery.

(9) Compliance shall issue an order consenting to the suspension of compensation by an insurer for any period of time during which a worker refuses to submit to recommended medical or surgical treatment reasonably essential to promote recovery. The consent to suspension of compensation shall continue until the date the worker has, in fact, consented to the recommended medical or surgical treatment and no compensation shall be due or paid during such period. When the worker has established a pattern of noncooperation, Compliance may require the worker to begin recommended treatment before compensation shall be restarted.

(10) The insurer shall continually monitor the claim to ascertain when the worker has, in fact, consented to the recommended medical or surgical treatment. When it is established that consent has been given, payment of compensation benefits shall commence effective on the date the consent was given and the insurer shall immediately notify Compliance by letter of the date of resumption.

(11) The insurer may request an administrative order of closure be issued by Evaluation if the worker has made no effort to have compensation reinstated within 60 days after Compliance has authorized suspension of compensation.

(12) The Compliance order consenting to the suspension of compensation by an insurer shall contain a notice, in prominent or bold-face type, as follows:

"IF YOU THINK THIS ORDER IS NOT RIGHT YOU MAY REQUEST A RECONSIDERATION OR A HEARING. REQUEST FOR RECONSIDERATION MUST BE IN WRITING AND SENT TO THE COMPLIANCE SECTION, WORKERS' COMPENSATION DIVISION, DEPARTMENT OF INSURANCE AND FINANCE, LABOR & INDUSTRIES BLDG., SALEM, OR 97310. HEARING REQUESTS MUST BE SENT TO THE HEARINGS DIVISION, WORKERS' COMPENSATION BOARD, 480 CHURCH STREET SE, SALEM, OR 97310."

(13) When the suspension is not approved, Compliance shall notify the insurer of the reason for denial.

Hist: Filed 12/11/70 as WCB Admin. Order 16-1970
Amended 4/27/78 as WCD Admin. Order 6-1978, eff. 4/27/78
Amended 1/11/80 as WCD Admin. Order 1-1980, eff. 1/11/80
Amended 12/23/81 as WCD Admin. Order 6-1981, eff. 1/1/82
Amended 12/29/83 as WCD Admin. Order 8-1983, eff. 1/1/84
Renumbered from 436-54-286, May 1, 1985
Amended 12/12/85 as WCD Admin. Order 8-1985, eff. 1/1/86
Amended 12/18/87 as WCD Admin. Order 4-1987, eff. 1/1/88

PETITION FOR REDUCTION OF BENEFITS; WORKER'S FAILURE TO FOLLOW MEDICAL ADVICE OR PARTICIPATE IN OR COMPLETE PHYSICAL RESTORATION OR VOCATIONAL REHABILITATION PROGRAMS OR COMMISSION OF INSANITARY OR INJURIOUS PRACTICES

436-60-130 (1) The Director or insurer which determines that a worker has failed to follow the medical advice of the attending physician or has committed an insanitary or injurious practice or has failed to participate in or complete physical restoration or vocational rehabilitation programs may petition for a reduction of benefits awarded the worker when determination is made pursuant to ORS 656.268.

(a) The petition for reduction of benefits will be sent to Evaluation.

(b) The petition shall contain all pertinent facts necessary to support the action requested and shall be accompanied by documentation to adequately demonstrate the worker's commission of an insanitary or injurious practice or failure to follow the attending physician's medical advice or participate in or complete physical restoration or vocational rehabilitation programs. Documentation may consist of telephone memoranda, doctor's reports, copies of correspondence, investigative reports or any other written evidence of the worker's failure to cooperate.

(2) Evaluation shall, in the absence of a petition from an employer or an insurer, reduce a worker's benefits when it comes to the attention of Evaluation that the worker has committed an insanitary or injurious practice or failed to follow the medical advice of the attending physician or has failed to participate in or complete physical restoration or vocational rehabilitation programs. Evaluation, if necessary, may require other information from the insurer to adequately demonstrate the worker's commission of an insanitary or injurious practice or failure to follow the attending physician's medical advice or participate in or complete physical restoration or vocational rehabilitation programs prescribed for the worker pursuant to ORS Chapter 656 and WCD Administrative Rules.

(3) Evaluation shall, upon determination of the worker's claim pursuant to ORS 656.268 and after considering any petition for reduction of benefits as described in section (1) or under the provisions of section (2), reduce the benefits awarded by the amount the disability has been increased by the

worker's commission of an insanitary or injurious practice or failure to follow medical advice from his attending physician or to participate in or complete physical restoration or vocational rehabilitation programs. Any reduction shall be demonstrated in the Determination Order by the amount of disability which would have been awarded and the amount of the award ultimately resulting from the worker's failure to cooperate.

Hist: Filed 12/11/70 as WCB Admin. Order 16-1970
Amended 4/27/78 as WCD Admin. Order 6-1978, eff. 4/27/78
Amended 1/11/80 as WCD Admin. Order 1-1980, eff. 1/11/80
Amended 12/23/81 as WCD Admin. Order 6-1981, eff. 1/1/82
Amended 12/29/83 as WCD Admin. Order 8-1983, eff. 1/1/84
Renumbered from 436-54-287, May 1, 1985
Amended 12/12/85 as WCD Admin. Order 8-1985, eff. 1/1/86
Amended 12/18/87 as WCD Admin. Order 4-1987, eff. 1/1/88

ACCEPTANCE OR DENIAL OF A CLAIM

436-60-140 (1) Written notice of acceptance or denial of a claim shall be furnished to the claimant by the insurer within 60 days after the employer has notice or knowledge of the claim.

(2) Any insurer who is delinquent in accepting or denying a claim beyond the statutory 60 days in excess of 5 percent of their total volume of reported claims during any quarter may receive a penalty assessed by the Director.

(3) The notice of acceptance in compliance with ORS 656.262 and the rules of Practice and Procedure for Contested Cases under the Workers' Compensation Law shall:

(a) inform the worker whether the claim is considered disabling or nondisabling;

(b) inform the worker of the Expedited Claim Service, of hearing and aggravation rights concerning nondisabling injuries including the right to object to a decision that the injury is nondisabling by requesting a determination pursuant to ORS 656.268;

(c) inform the worker of employment reinstatement rights and responsibilities under ORS Chapter 659;

(d) inform the worker of assistance available to employers from the Workers' Reemployment Reserve under ORS 656.622; and

(e) inform the worker that expenses personally paid for claim related expenses up to a maximum established rate shall be reimbursed by the insurer when requested in writing and accompanied by sales slips, receipts, etc., for meals, lodging, transportation, prescriptions and other expenses.

(4) The notice of denial in compliance with the rules of Practice and Procedure for Contested Cases under the Workers' Compensation Law shall:

(a) specify the factual and legal reasons for denial; and

(b) inform the worker of the Expedited Claim Service and of hearing rights under ORS 656.283.

(5) The insurer shall send notice of the denial to each provider of medical services and health insurance when compensability of all, or any portion, of a claim for medical services is denied. When the compensability issue has been finally determined the insurer shall notify each affected

medical service provider and each health insurance provider of the results of the determination, including the results of proceedings under ORS 656.289(4) and the amount of any settlement.

(6) The insurer shall or the employer may make payment of compensation due pursuant to ORS 656.262 and 656.273 and continue until such time as the claim is denied, except where there is an issue concerning the timely filing of a notice of accident as provided in ORS 656.265(4). The insurer shall report to Compliance payments of compensation made by the employer as if the insurer had made the payment.

(7) Pending acceptance or denial of a claim, compensation payable to a worker or the worker's beneficiaries does not include the costs of medical benefits or burial expense.

Hist: Filed 1/11/80 as WCD Admin. Order 1-1980, eff. 1/11/80
Amended 12/23/81 as WCD Admin. Order 6-1981, eff. 1/1/82
Amended 12/29/83 as WCD Admin. Order 8-1983, eff. 1/1/84
Renumbered from 436-54-300, May 1, 1985
Amended 12/12/85 as WCD Admin. Order 8-1985, eff. 1/1/86
Amended 12/18/87 as WCD Admin. Order 4-1987, eff. 1/1/88

TIMELY PAYMENT OF COMPENSATION

436-60-150 (1) Benefits shall be deemed paid when deposited in the U.S. Mail addressed to the last known address of the worker or beneficiary. Notice of the method and manner of such payment shall be provided as prescribed by the Director.

(2) The acceptable timeliness of first payment of time loss by the employer or insurer shall be no less than the previous fiscal year's average of the respective entities rounded to the nearest 5th percentage point, but in no event less than 80% for a guaranty contract insurer and 90% for a self-insured employer. An insurer falling below these norms during any quarter may receive a penalty assessed by the Director.

(3) Timely payment of temporary disability benefit has been made when paid no later than the 14th day after:

(a) employer's notice or knowledge of the claim if temporary disability is immediate and payable;

(b) employer's notice or knowledge of temporary disability related to but subsequent to the injury, which is payable;

(c) start of vocational training, if a claim has previously been determined;

(d) date the subject employer, or their insurer, has notice or knowledge of medically verified inability to work due to an aggravation of the worker's condition;

(e) date of any determination or litigation order which orders temporary disability;

(f) date a claim has been referred by the Department to the insurer for processing pursuant to ORS 656.029; or

(g) date a noncomplying employer claim has been referred by the Department to the SAIF Corporation.

(4) Continued temporary disability due shall be paid to within 7 days of the date of payment at least once each 14 days thereafter. The employer, when making payments as provided in OAR 436-60-020(1), may make subsequent payments of temporary disability concurrently with the normal payroll schedule of the employer, rather than in the regular 14-day intervals.

(5) Timely payment of permanent disability benefit has been made when paid no later than the 30th day after:

(a) date of determination order by the Department or notice of claim closure by the insurer; or

(b) date of any litigation order which orders permanent disability.

(6) Subsequent payments of permanent disability benefits are made in monthly sequence as earned. Adjustments to monthly payment dates may be made by the insurer, but the worker shall be advised of the adjustment, and no payment period shall exceed one month.

(7) Timely payment of medical services or goods shall be deemed made when paid within 60 days of the receipt of statement. When there is a dispute over the amount of a bill or the necessity of services rendered, the insurer will pay the undisputed amount. Resolution of the disputed amount will be made in accordance with OAR 436-10.

(8) The insurer shall notify the claimant or provider of service in writing when compensation is paid of the specific purpose of the payment. When applicable, the notice shall indicate the time period for which the payment is made and the reimbursable expenses or other bills and charges covered. If any portion of the claim is denied, the notice shall identify that portion of the claimed amounts that is not being paid.

Amended 1/11/80 as WCD Admin. Order 1-1980, eff. 1/11/80
Amended 12/23/81 as WCD Admin. Order 6-1981, eff. 1/1/82
Amended 12/29/83 as WCD Admin. Order 8-1983, eff. 1/1/84
Renumbered from 436-54-310, May 1, 1985
Amended 12/12/85 as WCD Admin. Order 8-1985, eff. 1/1/86
Amended 12/18/87 as WCD Admin. Order 4-1987, eff. 1/1/88

USE OF SIGHT DRAFT TO PAY COMPENSATION PROHIBITED

436-60-160 A sight draft shall not be used to make payment of any benefits due a worker or beneficiary under ORS Chapter 656. Such benefits include temporary disability, permanent disability and reimbursement of costs paid directly by the worker.

Hist: Filed 12/19/75 as WCB Admin. Order 18/1975, eff. 1/1/76
Amended 4/27/78 as WCD Admin. Order 6-1978, eff. 4/27/78
Amended 1/11/80 as WCD Admin. Order 1-1980, eff. 1/11/80
Amended 12/29/83 as WCD Admin. Order 8-1983, eff. 1/1/84
Renumbered from 436-54-315, May 1, 1985
Amended 12/12/85 as WCD Admin. Order 8-1985, eff. 1/1/86

RECOVERY OF OVERPAYMENT OF BENEFITS

436-60-170 (1) Insurers may recover overpayment of benefits paid to a worker through the procedure specified by ORS 656.268(10).

(2) Recovery of overpayment by the insurer shall be explained in written form to the worker, and the worker's attorney if represented, or to the dependent(s) of the worker if a fatality, and include:

(a) an explanation for the reason of overpayment;

(b) the amount of the overpayment; and

(c) the method of recovery of the overpayment.

Hist: Filed 1/11/80 as WCD Admin. Order 1-1980, eff 1/11/80
Amended 12/23/81 as WCD Admin. Order 6-1981, eff 1/1/82
Amended 12/29/83 as WCD Admin. Order 8-1983, eff 1/1/84
Amended 4/4/84 as WCD Admin. Order 3-1984, eff 4/4/84
Renumbered from 436-54-320, May 1, 1985
Amended 12/12/85 as WCD Admin. Order 8-1985, eff. 1/1/86
Amended 12/18/87 as WCD Admin. Order 4-1987, eff. 1/1/88

DESIGNATION AND RESPONSIBILITY OF A PAYING AGENT

436-60-180 (1) For the purpose of this rule:

(a) "Compensable injury" means an accidental injury, or accidental injury to prosthetic appliances, arising out of and in the course of employment requiring medical services or resulting in disability or death; an injury is accidental if the result is an accident, whether or not due to accidental means.

(b) "Responsibility" means liability under the law for the acceptance and processing of a compensable injury claim.

(2) Compliance shall, by order, designate who shall pay a claim, if the employers and insurers admit that the claim is otherwise compensable, where there is an issue regarding:

(a) which of several subject employers is the true employer of a claimant worker;

(b) which of more than one insurer of a certain employer is responsible for payment of compensation to a worker;

(c) responsibility between two or more employers or their insurers involving payment of compensation for two or more accidental injuries; or

(d) joint employment by two or more employers.

(3) With the consent of the Workers' Compensation Board, Own Motion claims are subject to the provisions of this rule.

(4) Insurers with knowledge of a situation as defined in section (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.

(5) When a situation as described in section (2) is identified, the insurers shall immediately notify any other affected insurers of the situation. A copy of all medical reports or other pertinent material available relative to the injury shall be provided the other parties with the notification.

(6) Such notice received from another insurer shall be notice of a claim referred by the Director as provided by ORS 656.265(3).

(7) Upon determining an issue exists as to the responsibility for an

otherwise compensable injury, an insurer shall request a paying agent be designated by application in letter form to Compliance. The application shall contain the following information:

(a) designation of a paying agent is requested pursuant to ORS 656.307;

(b) acknowledgment that the injury to the worker is otherwise a compensable injury, but

(c) responsibility is an issue;

(d) identification of all parties and claims involved;

(e) acknowledgment that medical reports or other pertinent material available relative to the injury have been provided the other parties; and

(f) acknowledgment that notice has been provided the worker explaining the current actions being taken on the worker's claim.

(8) Compliance shall not designate a paying agent where there remains an issue of whether the injury is a compensable injury claim or if the 60 days appeal period of a denial has expired without a request for a paying agent or a request for a hearing on the denial being received by the Division or Board.

(9) When notified by Compliance that there is a reasonable doubt as to the status of the claim or intent of a denial, the insurers shall provide written clarification to Compliance within 10 days of the date of the notification.

(10) Compliance, upon receipt of a request for designation of a paying agent from the worker or someone on the worker's behalf, shall forward a copy of the request to the insurers involved.

(11) Insurers receiving notice from the Department of a worker's request for designation of a paying agent shall immediately process the request in accordance with sections (4) through (7).

(12) Compliance, upon receipt of written acknowledgment from the insurers that the only issue is responsibility of an otherwise compensable injury claim, shall issue an order designating a paying agent pursuant to ORS 656.307. The insurer paying the lowest temporary disability rate, or if the same, the earliest claim shall be designated the paying agent. The designated paying agent shall make the first payment of temporary disability within 14 days after the date of Compliance order.

(13) Compliance, by copy of its order, shall refer the matter to the Workers' Compensation Board to set an arbitration proceeding pursuant to ORS 656.307 to determine the issue of responsibility of benefits to the worker.

(14) The designated paying agent shall process the claim as an accepted claim through determination unless relieved of the responsibility by an order of the arbitrator. Compensation paid under the order shall include all benefits, including medical services, provided for a compensable injury to a subject worker or the worker's beneficiaries. The payment of temporary disability due shall be for periods subsequent to periods of disability already paid by any insurer.

Hist: Filed 1/11/80 as WCD Admin. Order 1-1980, eff. 1/11/80
Amended 4/29/80 as WCD Admin. Order 5-1980, eff. 4/29/80
(Temporary)

Amended 10/1/80 as WCD Admin. Order 7-1980, eff. 10/1/80
Amended 12/29/83 as WCD Admin. Order 8-1983, eff. 1/1/84
Renumbered from 436-54-332, May 1, 1985
Amended 12/12/85 as WCD Admin. Order 8-1985, eff. 1/1/86
Amended 12/18/87 as WCD Admin. Order 4-1987, eff. 1/1/88

MONETARY ADJUSTMENTS AMONG PARTIES AND DEPARTMENT OF INSURANCE AND FINANCE

436-60-190 (1) An order pursuant ORS 656.307 and OAR 436-60-180 shall apply only to the period prior to the order of the arbitrator determining the responsible paying party. Payment of compensation made thereafter shall not be recovered from the Insurance and Finance Fund, except where the Director concludes payment was made after the date of the order of the arbitrator, but before the order was received by the paying agent designated under OAR 436-60-180.

(2) When all litigation on the issue of responsibility is final, and the responsible paying party has been determined, Compliance shall direct any necessary monetary adjustment between the parties involved which is not ordered or that cannot be voluntarily resolved by the parties. Any failure to obtain reimbursement from an insurer for compensation paid as a result of an order pursuant OAR 436-60-180 shall be recovered from the Insurance and Finance Fund.

(3) When poor or untimely claim processing by the designated paying agent results in unnecessary cost to a claim, Compliance may deny the right to reimbursement for the unnecessary cost from either the responsible paying agent or the Insurance and Finance Fund.

(4) When the responsibility issue is decided by a stipulated settlement, the monetary adjustment between the parties shall not be recovered from the Insurance and Finance Fund.

(5) When the compensability of a claim becomes an issue subsequent to the designation of a paying agent, Compliance shall order termination of any further benefits due from the original order designating a paying agent. The designated paying agent will be responsible for ensuring the issue of responsibility continues to arbitration as well as joining the issue of whether the claim is a compensable injury claim. Failure to seek a conclusion to the issue of responsibility by arbitration shall preclude the designated paying agent from recovering from the Insurance and Finance Fund.

Hist: Filed 6/3/70 as WCB Admin. Order 5-1970
Amended 1/11/80 as WCD Admin. Order 1-1980, eff. 1/11/80
Amended 4/29/80 as WCD Admin. Order 5-1980, eff. 4/29/80 (Temporary)
Amended 10/1/80 as WCD Admin. Order 7-1980, eff. 10/1/80
Amended 12/23/81 as WCD Admin. Order 6-1981, eff. 1/1/82
Amended 12/29/83 as WCD Admin. Order 8-1983, eff. 1/1/84
Renumbered from 436-54-334, May 1, 1985
Amended 12/12/85 as WCD Admin. Order 8-1985, eff. 1/1/86
Amended 12/18/87 as WCD Admin. Order 4-1987, eff. 1/1/88

ASSESSMENT OF CIVIL PENALTIES

436-60-200 (1) The Director through Compliance and pursuant to ORS 656.745 shall assess a civil penalty against an employer or insurer who intentionally or repeatedly induces claimants for compensation to fail to report accidental injuries, causes employes to collect accidental injury claims as off-the-job injury claims, persuades claimants to accept less than

the compensation due or makes it necessary for claimants to resort to proceedings against the employer to secure compensation due. For the purpose of this section:

(a) "Intentionally" means the employer or insurer acted with a conscious objective to cause any result described in ORS 656.745(1) or to engage in the conduct so described in that section.

(b) "Repeatedly" means more than once in any twelve month period.

(2) The Director through Compliance and pursuant to ORS 656.745 may assess a civil penalty against an employer or insurer who fails to comply with rules and orders of the Director regarding reports or other requirements necessary to carry out the purposes of the Workers' Compensation Law.

(3) An employer or insurer failing to meet the time frame requirements of Oregon Administrative Rules 436-60-010, 436-60-060, 436-60-070 and 436-60-180 may be assessed a civil penalty up to $1,000.

(4) An insurer who willfully violates Oregon Administrative Rule 436-60-160 shall be assessed a civil penalty of $1,000.

(5) Notwithstanding section (3) of this rule, an insurer who does not comply with the claims processing requirements of the statutes, and rules and orders of the Director relating thereto may be assessed a civil penalty of up to $2,000 for each violation or $10,000 in the aggregate for all violations within any three month period.

(6) For the purpose of section (5), statutory claims processing requirements would include but not be limited to, ORS 656.202, ORS 656.210, ORS 656.212, ORS 656.228, ORS 656.234, ORS 656.236, ORS 656.245, ORS 656.262, ORS 656.263, ORS 656.264, ORS 656.265, ORS 656.268, ORS 656.273, ORS 656.307, ORS 656.325, ORS 656.331 and ORS 656.335.

(7) In arriving at the amount of penalty Compliance may, but is not limited to, consider:

(a) the ratio of the volume of violations to the volume of claims reported, or

(b) the ratio of the volume of violations to the average volume of violations for all insurers or self-insured employers, and

(c) prior performance in meeting the requirements as outlined in this section.

(8) When a penalty, based upon ratios, is appropriate and the volume to which the volume of errors are compared is 10 or less, Compliance shall assess no more than $200 regardless of the percentage of error. When, however, the volume exceeds 10 Compliance will assess a penalty of $25 per percentage point over the acceptable level or $200 whichever is greater.

Hist: Filed 1/11/80 as WCD Admin. Order 1-1980, eff. 1/11/80
Amended 12/23/81 as WCD Admin. Order 6-1981, eff. 1/1/82
Amended 12/29/83 as WCD Admin. Order 8-1983, eff. 1/1/84
Renumbered from 436-54-981, May 1, 1985
Amended 12/12/85 as WCD Admin. Order 8-1985, eff. 1/1/86
Amended 12/18/87 as WCD Admin. Order 4-1987, eff. 1/1/88

ISSUANCE/SERVICE OF PENALTY ORDERS

436-60-210 (1) When a penalty is assessed as provided by OAR 436-60-200 , Compliance shall cause an order, with a notice of the rights provided under ORS 656.740, to be served on the party. If the party requests a hearing on the proposed assessment, Compliance shall furnish the Department of Justice with pertinent records in the matter as requested.

(2) Compliance shall serve the Order:

(a) by delivering a copy of the Order to the party in the manner provided by ORCP 7D.(3); or

(b) by sending a copy of the Order to the party by certified mail with return receipt requested.

Hist: Filed 1/11/80 as WCD Admin. Order 1-1980, eff. 1/11/80
Amended 12/29/83 as WCD Admin. Order 8-1983, eff. 1/1/84
Renumbered from 436-54-983, May 1, 1985
Amended 12/12/85 as WCD Admin. Order 8-1985, eff. 1/1/86
Amended 12/18/87 as WCD Admin. Order 4-1987, eff. 1/1/88

EXHIBIT "B"

**BEFORE THE DIRECTOR OF THE
DEPARTMENT OF INSURANCE AND FINANCE
OF THE STATE OF OREGON**

In the Matter of the Amendment of Rules Governing Claims Administration (OAR Chapter 436, Workers' Compensation Division, Division 60).	)))))	CITATION OF STATUTORY AUTHORITY, STATEMENT OF NEED, PRINCIPAL DOCUMENTS RELIED UPON, AND STATEMENT OF FISCAL IMPACT

1. Citation of Statutory Authority. The Statutory Authority for promulgation of these rules is ORS 656.210(2), 656.264, 656.265(6),656.325, 656.726(3)(a), 656.331 and 656.335.

2. Need for Rules. The need for such rules is to govern the provisions of claims administration in accordance with existing law and statutory amendments passed by the 1987 Legislature.

3. Principal Documents Relied Upon. The commands of the statutes above referenced create the need for these rules. No other principal documents, reports, or studies were relied upon.

4. Fiscal and Economic Impact. The following entities are economically affected: (a) state agencies, in their role of employer; (b) units of local government, in their role of employer; (c) large and small private sector employers subject to the Workers' Compensation Law; and (d) insurance companies processing workers' compensation claims.

The economic effect of promulgating these rules should result in savings to large and small employers within the workers' compensation system. The actual amount cannot be determined, but it could be considerable.

DATED THIS 18 DAY OF DECEMBER, 1987

Department of Insurance and Finance

Theodore R. Kulongoski, Director

BEFORE THE DIRECTOR OF THE
DEPARTMENT OF INSURANCE AND FINANCE
OF THE STATE OF OREGON

WCD Admin. Order 10-1987

In the Matter of the Amendment of Rules Governing Claims Administration (OAR Chapter 436, Workers' Compensation Division, Division 60).	)))))	ORDER OF ADOPTION OF TEMPORARY RULE

The Director of the Department of Insurance and Finance, pursuant to the rulemaking authority in ORS 656.726(3)(a); and in accordance with the procedure provided by ORS 183.335, amends OAR Chapter 436, Workers' Compensation Division, Division 60, Claims Administration.

The amendment is being adopted by Temporary Rule, as provided by ORS 183.335(5) and (6), without prior notice. Statement of Findings: I conclude that failure to act promptly will result in serious prejudice to employers through additional or improper premium charges; to workers whose rights under the worker's compensation law could be jeopardized and to insurers and self-insured employers from paying additional or unnecessary costs or from being penalized for improper claims processing.

The need for such rules is to provide: (1) A policy and procedure on how the employer will pay the amount of $500 per claim for a nondisabling claim in accordance with ORS 656.262(5), and (2) A policy and procedure on how the costs of the arbitration proceeding shall be shared by the parties in accordance with ORS 656.307(2).

IT IS THEREFORE ORDERED:

(1) OAR Chapter 436, Divisions 60-055 and 60-185 as set forth in Exhibit "A" attached hereto, certified a true copy and hereby made a part of this order are temporarily adopted effective January 1, 1988.

(2) A certified true copy of the Order of Adoption and these Rules, Exhibit "A", with Exhibit "B" consisting of the Citation of Statutory Authority, Statement of Need and Documents Relied Upon, hereby made a part of this Order, be filed with the Secretary of State.

(3) A copy of the Rules and attached Exhibit "B" be filed with the Legislative Counsel, pursuant to the provisions of ORS 183.715 within 10 days after filing with the Secretary of State.

Dated this 18 day of December, 1987.

DEPARTMENT OF INSURANCE AND FINANCE

Theodore R. Kulongoski

Theodore R. Kulongoski, Director

EXHIBIT "A"

OREGON ADMINISTRATIVE RULES
CHAPTER 436. WORKERS' COMPENSATION DIVISION
DIVISION 60: CLAIMS ADMINISTRATION

PAYMENT OF MEDICAL SERVICES ON NONDISABLING CLAIMS; EMPLOYER/INSURER RESPONSIBILITY

436-60-055 Pursuant to ORS 656.262(5) the costs of medical services for nondisabling claims, in amounts not to exceed $500 per claim, may be paid by the employer if the employer so chooses. Such choice does not relieve the employers of their claim reporting requirements or the insurers of their responsibility to determine entitlement to benefits and process the claims accurately and timely. Also, when paid by the employer, such costs cannot in any way be used to affect the employer's experience rating modification or otherwise charged against the employer. To enable the Department to ensure these conditions are met, insurers and employers must comply with the following process and procedures:

(1) Notwithstanding the choice made by the employer pursuant to section (2) of this rule, the employer and insurer shall process the nondisabling claims in accordance with all statutes and rules governing claims processing. The employer, however, shall reimburse the medical service costs paid by the insurer if the employer has chosen to make such payments. The method and manner of reimbursement by the employer shall be established in the written agreement required by Section (2) of this rule, prior to any payments being made by the employer. In no case, however, shall the employer have less than 30 days to reimburse the insurer.

(2) Prior to the commencement of each policy year, the insurer shall send a notice to the insured or prospective insured, advising of the employer's right to reimburse medical service costs up to $500 on nondisabling claims. The Notice, in a form and format prescribed by the Director by way of bulletin, shall advise the employer that one of the following choices are available for making such reimbursement and the effect of such choice:

(a) To reimburse up to $500 in medical service costs on all nondisabling claims. This choice would be made by an endorsement issued by the insurer, resulting in proper application of appropriate premium rate adjustments, if any. The endorsement and rate adjustments are subject to approval by the Insurance Division.

(b) To reimburse up to $500 in medical service costs on a pre-selected number of nondisabling claims without regard to the dollar amount of those costs. This choice would be made by written agreement between the employer and the insurer, the agreement becoming part of the permanent record of the employer's losses.

(c) To reimburse up to $500 in medical service costs on the nondisabling claims up to a pre-determined total dollar amount without regard to the number of nondisabling claims. This choice would be made by written agreement between the employer and the insurer, the agreement becoming part of the permanent record of the employer's losses.

(d) To reimburse up to $500 in medical service costs on those non-disabling claims chosen by the employer at the time a claim is accepted and determined nondisabling by the insurer. This method shall be made by written agreement between the employer and the insurer and as prescribed in section (3) of this rule, the agreement becoming part of the permanent record of the employer's losses; or

(e) Not to reimburse the medical service costs of any nondisabling claim.

(3) When selecting to reimburse medical service costs as provided in section (2)(d) of this rule the following process shall be followed: At the time the employer receives notice from the insurer indicating the claim is accepted and nondisabling, the employer shall determine and notify the insurer of their intention to reimburse up to $500 medical service costs on the claim. The time frame for the employer to notify the insurer of the intention to make such reimbursement shall be established in the written agreement required in paragraph (2)(d) of this rule. The form used to notify the insurer of the employer's intention shall be provided to the employer by the insurer. The minimum information that must be included in the notice is:

(a) That it is a notice of the employer's election to reimburse the claim costs;

(b) The name and address of the employer;

(c) The claimant's name and Social Security Number, the date of injury and the claim number;

(d) The insurer's name and address.

(4) If the employer fails to reimburse the insurer in accordance with the agreement, the insurer shall advise the employer in writing that future delinquencies in payment will result in the costs being charged to the employer. If a subsequent delinquency occurs, the insurer shall send another written notice. Any delinquency thereafter shall void the agreement for the remainder of that policy period. The provisions of this section shall be included in the Notice and written agreements required pursuant to section (2) of this rule.

(5) Insurers shall maintain records of amounts reimbursed by employers for medical services on nondisabling claims. Insurers, however, shall not modify an employer's experience rating or otherwise make charges against the employer for any medical services reimbursed by the employer. For employers on retrospective rated plans, medical costs paid by the employer on nondisabling claims shall be included in the retrospective premium calculation, but the amount paid by the employer shall be applied as credits against the resulting retrospective premium.

(6) If a claim changes from a nondisabling to a disabling claim and the insurer has recovered reimbursement from the employer for medical costs prior to the change, the insurer shall exclude those amounts reimbursed from any experience rating, retrospective rating, or other individual or group rating plans of the employer.

(7) Insurers who do not comply with the requirements of this rule or in any way prohibit an employer from making a selection pursuant to section (2) of this rule, shall be subject to a penalty as provided by OAR 436-60-200(5).

(8) Self-insured employers shall maintain records of all amounts paid for medical services on nondisabling claims in accordance with OAR 436-50-220. When reporting loss data for experience rating, the self-insured may exclude costs for medical services paid on nondisabling claims in amounts not to exceed $500 per claim.

Hist: Filed 12-20-87 as WCD Admin. Order 10-1987, effective 1-1-88 (Temporary)

ARBITRATION PROCEEDINGS COSTS ALLOCATION

436-60-185 (1) The cost of the arbitration proceedings conducted by the Board pursuant to ORS 656.307 and OAR 438-14 shall be equally shared between the insurers involved in the arbitration proceedings as identified by the "Arbitrator's Decision" issued pursuant to OAR 438-14-025.

(2) When the "Arbitrator's Decision" is received by Compliance, a copy of the Order shall be forwarded to the Department's Fiscal Section for collection.

Hist: Filed 12-20-87 as WCD Admin. Order 10-1987, effective 1-1-88 (Temporary)

(for WCD Admin. Order 10-1987)

EXHIBIT "B"

BEFORE THE DIRECTOR OF THE
DEPARTMENT OF INSURANCE AND FINANCE
OF THE STATE OF OREGON

In the Matter of the Amendment of Rules Governing Claims Administration (OAR Chapter 436 Workers' Compensation Division, Division 60).	)))))	Statutory Authority, Statement of Need, Principal Documents Relied Upon, and Statement of Fiscal Impact

1. Citation of Statutory Authority. The Statutory Authority for promulgation of these rules is ORS 656.726(3)(a).

2. Need for Rules. The need for such rules is:

   a. To prescribe policy and procedures for employers choosing to pay medical service costs as provided by ORS 656.262(5) to ensure such costs are not charged to or affect employers' premium, while still ensuring that claims are processed accurately and timely and workers' rights are not jeopardized; and

   b. To prescribe policy and procedure on how the costs of arbitration proceedings held pursuant to ORS 656.307(2) are to be shared among the parties to the proceedings.

3. Principal Documents Relied Upon.

   a. ORS Chapter 656.262(5) and 656.307(2)
   b. SAIF Corporation's testimony on the proposed rules governing Claims Administration regarding Payment of Medical Services OAR 436-60-050.
      SAIF Corporation letter dated 12-4-87 concerning OAR 436-60-050 and signed by John Gilkey, Policy Underwriting Manager.
      Liberty Northwest Insurance Corporation's testimony on the proposed rules governing Claims Administration regarding the payment of medical services, OAR 436-60-050, submitted by Daryl L. Nelson, Vice President and General Counsel.

   The above documents are available for public inspection at the offices of the Administrator, Workers' Compensation Division, 200 Labor and Industries Building, Salem, OR 97310, during regular business days, 8 a.m. to 5 p.m., Monday through Friday.

4. Fiscal and Economic Impact. The following entities are economically affected: (a) state agencies, in their role of employer; (b) units of local government, in their role of employer; (c) large and small private sector employers subject to the Workers' Compensation Law; (d) injured workers and (e) insurance companies and self-insured employers processing workers' compensation claims.

The economic effect of promulgating these rules should result in savings to large and small employers within the workers' compensation system. The actual amount cannot be determined, but it could be considerable.

DATED THIS 18 DAY OF DECEMBER, 1987.

DEPARTMENT OF INSURANCE AND FINANCE

Theodore R. Kulongoski

Theodore R. Kulongoski, Director

ASSISTANCE FROM WORKERS' REEMPLOYMENT RESERVE

Oregon Administrative Rules, Chapter 436

Division 110
Effective January 1, 1988

Department of Insurance and Finance
Workers' Compensation Division
Salem, Oregon 97310

BEFORE THE DIRECTOR OF THE DEPARTMENT OF INSURANCE AND FINANCE OF THE STATE OF OREGON

In the Matter of the Amendment of OAR Chapter 436, Workers' Compensation Division, Division 110, Assistance from the Workers' Reemployment Reserve	)))))	ORDER OF ADOPTION

The Director of the Department of Insurance and Finance, pursuant to the rulemaking authority in ORS 656.726(3) and the procedure in ORS 183.335, amends OAR Chapter 436, Workers' Compensation Division, Division 110, Assistance from the Workers' Reemployment Reserve.

On October 20, 1987, the Department of Insurance and Finance filed a Notice of Proposed Amendment of Rules with the Secretary of State. The statement of Statutory Authority, Need, Principal Documents Relied Upon and Fiscal Impact was also filed with the Secretary of State.

Copies of the notice were mailed to interested persons in accordance with OAR 436-01-000 and to those on the Department's distribution mailing list as their interest indicated. The notice was published in the November 1, 1987, Bulletin of the Secretary of State.

On November 23, 1987, a public hearing was held as announced. The hearing was subsequently adjourned until December 3, 1987, to receive additional written testimony. A summary of the Testimony and Agency Responses is contained in Exhibit "C". This Exhibit is on file and available for public inspection between the hours of 8 a.m. and 5 p.m., normal working days Monday through Friday, in the Administrator's Office, Workers' Compensation Division, Department of Insurance and Finance, Room 200, Labor and Industries Building, Salem, Oregon 97310.

Having reviewed and considered the record of public hearing, and being fully advised, I make the following findings under the authority granted by ORS 656.726(3):

(1) The applicable statutues have been followed;
(2) The applicable rulemaking procedures have been followed;
(3) The rules are within the Director's authority; and
(4) After reviewing and considering data, views and arguments presented at the public hearing and in written testimony, the rules being adopted are reasonable and proper.

IT IS THEREFORE ORDERED:

(1) OAR Chapter 436, Division 110, Assistance from the Workers' Reemployment Reserve, as set forth in Exhibit "A" attached thereto, certified a true copy and hereby made a part of this order, be adopted this date, to be effective January 1, 1988.

(2) OAR 436-110-009 is repealed effective January 1, 1988.

(3) A certified true copy of the Order of Adoption and these rules, with Exhibit "B" consisting of the Citation of Statutory Authority, Statement of Need, Documents Relied Upon, and Statement of Fiscal Impact, attached and hereby made a part of this order, be filed with the Secretary of State.

(4) A copy of the Rules and attached Exhibit "B" be filed with the Legislative Counsel, pursuant to the provisions of ORS 183.715, within 10 days after filing with the Secretary of State.

Dated this 16th day of December, 1987

Department of Insurance and Finance

Theodore R. Kulongoski

Theodore R. Kulongoski, Director

EXHIBIT "A"

CHAPTER 436
DEPARTMENT OF INSURANCE AND FINANCE
WORKERS' COMPENSATION DIVISION
DIVISION 110

ASSISTANCE FROM THE WORKERS' REEMPLOYMENT RESERVE

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CHAPTER 436

DIVISION 110

ASSISTANCE FROM THE WORKERS' REEMPLOYMENT RESERVE

Authority for Rules

436-110-001 (1) The Director has adopted OAR 436-110 by the Director's authority under ORS 656.622 and ORS 656.726(3).

(2) An order of a division or section, issued under the Director's authority to administer ORS chapter 656 and rules adopted under that chapter, shall be considered an order of the Director.

Hist: Filed 1/2/73 as WCB Admin. Order 1-1973, eff. 1/15/73
Amended 3/14/73 by WCB Admin. Order 3-1973, eff. 4/1/73
Amended 9/29/77 as WCD Admin. Order 2-1977 (Temp.), eff. 10/4/77
Amended 2/1/78 as WCD Admin. Order 2-1978, eff. 2/1/78
Amended 12/30/81 as WCD Admin. Order 7-1981, eff. 1/1/82
Renumbered from OAR 436-63-001, 5/1/85
Amended 2/20/87 as WCD Admin. Order 1-1987, eff. 3/16/87
Amended 12/17/87 as WCD Admin. Order 12-1987, eff. 1/1/88

Purpose of Rules

436-110-002 The purpose of these rules is:

(1) To prescribe the terms of eligibility for reemployment assistance to workers and Oregon employers who reemploy or hire workers with disabling compensable injuries or diseases, and the nature and extent of the assistance, pursuant to ORS 656.622; and,

(2) To establish criteria for payment and reimbursement to insurers and employers from the reserve created in ORS 656.622.

Hist: Filed 2/20/87 as WCD Admin. Order 1-1987, eff. 3/16/87
Amended 12/17/87 as WCD Admin. Order 12-1987, eff. 1/1/88

Applicability of Rules

436-110-003 (1) These rules govern all requests for assistance from the Workers' Reemployment Reserve filed with the Director on and after January 1, 1988, except for assistance to sheltered workshops as provided in ORS 656.530.

(2) Requests for second injury relief filed in accordance with rules adopted under WCB Administrative Order 3-1973, on which the Board or Director issued a determination of eligibility prior to October 4, 1977, shall be processed and paid as provided for in that Administrative Order.

(3) Requests for second injury relief filed in accordance with rules adopted under WCD Administrative Order 2-1978, on which the Department issued a Wage Subsidy, Worksite Modification or Increased Cost Protection contract prior to January 1, 1982, shall be paid as provided in that Administrative Order.

(4) Employers with Increased Cost Protection contracts may also apply for relief in accordance with the provisions of the Handicapped Workers Reserve, OAR 436-40. If it appears that the total costs of the second injury will exceed the contractual limits of the Increased Cost Protection contract, the employer may seek Handicapped Workers Reserve benefits in order to reduce those costs to the $20,000 limit payable in accordance with the contract.

(5) Workers' Reemployment Reserve contracts approved by the Department prior to March 16, 1987, in accordance with rules adopted under WCD Administrative Order 7-1981, shall be paid as provided in that Administrative Order.

(6) Workers' Reemployment Reserve agreements approved by the Department prior to January 1, 1988, in accordance with rules adopted under WCD Administrative Order 1-1987, shall be paid as provided in that Administrative Order.

(7) The Director may waive provisions of these rules if the Director finds it necessary to carry out the provisions of ORS 656.622.

Hist: Filed 1/2/73 as WCB Admin. Order 1-1973, eff. 1/15/73
Amended 3/14/73 by WCB Admin. Order 3-1973, eff. 4/1/73
Amended 9/29/77 as WCD Admin. Order 2-1977 (Temp.), eff. 10/4/77
Amended 2/1/78 as WCD Admin. Order 2-1978, eff. 2/1/78
Amended 12/30/81 WCD Admin. Order 7-1981, eff. 1/1/82
Renumbered from OAR 436-63-005, 5/1/85
Amended 2/20/87 as WCD Admin. Order 1-1987, eff. 3/16/87
Amended 12/17/87 as WCD Admin. Order 12-1987, eff. 1/1/88

Definitions

436-110-005 As used in these rules:

(1) "Administrative approval" means an approval or finding in a particular matter by the administrator of the Workers' Compensation Division, or the administrator's delegate for the matter. "Prior administrative approval" means that such approval, or a waiver under OAR 436-110-003(7), has been secured before any commitment is made to provide assistance governed by these rules.

(2) "Department" means the Department of Insurance and Finance.

(3) "Director" means the Director of the Department of Insurance and Finance.

(4) "Division" means the Workers' Compensation Division of the Department of Insurance and Finance.

(5) "Employer" means a subject employer within the meaning of the Workers' Compensation Law who meets the require-

ments of all other applicable state and federal regulations. "Employer-at-injury" means the person in whose employ the worker sustained the injury or made the claim for aggravation which gave rise to the need for reemployment assistance.

(6) "Employment" used with certain modifiers has the following meanings:

(a) "Suitable employment" means permanent employment of the kind for which the worker has the necessary physical capacities, knowledge, skills or abilities, and providing a wage as close as possible to the wage currently being paid for employment which is the regular employment for the worker. For the purposes of this subsection:

(A) "Knowledge" means an organized body of factual or procedural information derived from the worker's education, training and experience.

(B) "Skills" means the demonstrated mental and physical proficiency to apply knowledge.

(C) "Abilities" means the mental and physical capability to apply the worker's knowledge and skills.

(b) "Permanent employment" means employment normally expected to last indefinitely subject to the employer's business practices and policies, collective bargaining agreement(s), applicable statutes and economic conditions.

(7) "Insurer" means the State Accident Insurance Fund Corporation, an insurer authorized under ORS Chapter 731 to transact workers' compensation insurance in Oregon, or a self-insured employer.

(8) "Preferred worker" means a worker who, because of a compensable injury, is unable to return to regular employment without substantial work or worksite modification and is eligible for assistance under these rules.

(9) "Reemployment assistance" means any of the goods and services under these rules for assisting employers in the reemployment or hiring of injured workers.

(10) "Section" means the Rehabilitation Review Section of the Workers' Compensation Division of the Department of Insurance and Finance.

(11) "Standard premium" means the results of a calculation which takes payroll multiplied by the applicable rates of the employer's individual insurer multiplied by the employer's experience rating modification.

(12) "Substantial obstacle" means a permanent physical or mental impairment resulting from a disabling, compensable injury, which limits or prevents a worker from engaging in suitable permanent employment.

(13) "Wages" mean the money rate at which the service rendered is recompensed under the contract of hiring, not including commission, tips, overtime, paid vacation, paid sick leave, other paid leave, board, housing, rent or other remuneration.

Hist: Filed 1/2/73 as WCB Admin. Order 1-1973, eff. 1/15/73
Amended 3/14/73 by WCB Admin. Order 3-1973, eff. 4/1/73
Amended 9/29/77 as WCD Admin. Order 2-1977 (Temp.), eff. 10/4/77
Amended 2/1/78 as WCD Admin. Order 2-1978, eff. 2/1/78
Amended 12/30/81 as WCD Admin. Order 7-1981, eff. 1/1/82
Renumbered from OAR 436-63-010, 5/1/85
Amended 2/20/87 as WCD Admin. Order 1-1987, eff. 3/16/87
Amended 12/17/87 as WCD Admin. Order 12-1987, eff. 1/1/88

Rehabilitation Review Section

436-110-006 The Rehabilitation Review Section is charged with assuring that injured workers and employers receive reemployment assistance pursuant to ORS 656.622 and these rules; and, maintaining the integrity of the Department's reimbursement of reemployment assistance costs.

Hist: Filed 2/20/87 as WCD Admin. Order 1-1987, eff. 3/16/87
Amended 12/17/87 as WCD Admin. Order 12-1987, eff. 1/1/88

Policy Governing Assistance from the Workers' Reemployment Reserve

436-110-010 (1) Assistance to employers from the Workers' Reemployment Reserve shall be provided in order to encourage employers to reemploy or hire workers who have a substantial obstacle to suitable employment.

(2) All employment for which reemployment assistance is granted shall be suitable employment.

(3) All reemployment assistance is subject to the conditions set forth in these rules.

Hist: Filed 1/2/73 as WCB Admin. Order 1-1973, eff. 1/15/73
Amended 3/14/73 by WCB Admin. Order 3-1973, eff. 4/1/73
Amended 9/29/77 as WCD Admin. Order 2-1977 (Temp.), eff. 10/4/77
Amended 2/1/78 as WCD Admin. Order 2-1978, eff. 2/1/78
Amended 12/30/81 as WCD Admin. Order 7-1981, eff. 1/1/82
Renumbered from OAR 436-63-015, 5/1/85
Amended 2/20/87 as WCD Admin. Order 1-1987, eff. 3/16/87
Amended 12/17/87 as WCD Admin. Order 12-1987, eff. 1/1/88

Criteria for Granting Assistance from the Workers' Reemployment Reserve; Eligibility and Ineligibility of Workers and Employers

436-110-020 An employer and worker are eligible for assistance from the Workers' Reemployment Reserve when the employer agrees to reemploy or hire the worker, the worker and employer are in compliance with all applicable state and federal statutes regarding employment, and:

(1) As a result of the injury the worker has not successfully returned to suitable employment and will not be able to return to the employment the worker held at the time of injury or the claim for aggravation, or the worker's customary employment.

(2) The worker has a substantial obstacle to employment resulting from the injury, and there is:

(a) A preponderance of medical evidence which indicates the disability would appear to be permanent; or

(b) The worker has a Determination Order, Order of a Referee, Order on Review by the Board, decision of the Court of Appeals or an approved stipulation which grants permanent disability.

(3) A worker is not eligible for reemployment assistance if the worker has intentionally misrepresented a matter material to the provision of reemployment assistance.

(4) An employer is not eligible for reemployment assistance if:

(a) The employer intentionally misrepresents a claim for reimbursement wages or submits reimbursement claims prior to paying the costs.

(b) The employer fails to provide or maintain Oregon workers' compensation insurance.

(c) The employer has established a pattern of terminating workers within 60 days after completion of the agreement.

(d) The employer fails to abide by any other provision of a reemployment assistance agreement, or these rules.

(5) An employer hiring a relative, patient, client, corporate officer or their relative, shareholder or other person with whom they have a relationship other than a usual employer-employe relationship, are not eligible for reemployment assistance without prior administrative approval.

(6) An employer failing to comply with these rules may be barred from receiving reemployment assistance for a period prescribed by the Director.

Hist: Filed 1/2/73 as WCB Admin. Order 1-1973, eff. 1/15/73
Amended 3/14/73 by WCB Admin. Order 3-1973, eff. 4/1/73
Amended 9/29/77 as WCD Admin. Order 2-1977 (Temp.), eff. 10/4/77
Amended 2/1/78 as WCD Admin. Order 2-1978, eff. 2/1/78
Amended 12/30/81 as WCD Admin. Order 7-1981, eff. 1/1/82
Renumbered from OAR 436-63-020, 5/1/85
Amended 2/20/87 as WCD Admin. Order 1-1987, eff. 3/16/87
Amended 12/17/87 as WCD Admin. Order 12-1987, eff. 1/1/88

Kinds and Conditions of Reemployment Assistance

436-110-035 The following kinds of reemployment assistance are available under the conditions set forth in this rule:

(1) Wage subsidy. A wage subsidy reimburses an employer for a portion of a preferred worker's wages for a specified period. A wage subsidy shall be limited in duration to six months, and shall not exceed a monthly rate of 50 percent reimbursement of wages paid by the employer, other than for a worker with an exceptional disability. "Exceptional disability" means a disability equivalent to the complete loss, or loss of use, of two or more limbs. The determination of whether a disability is exceptional requires administrative approval. In no case shall reimbursement exceed 75 percent of the wages paid in any one month.

(2) Worksite modification. A worksite modification alters the configuration of a worksite, or involves purchasing, modifying or supplementing equipment to enable a preferred worker to work within the limitations imposed by an injury. A worksite modification in excess of $1,000 requires prior administrative approval. A worksite modification shall be limited in any one case to $15,000, other than for a worker with an exceptional disability. Other conditions under OAR 436-110-090(5)(g) and (6) also apply. A worksite modification may include one or more of the following elements:

(A) Provision of tools, equipment, fixtures or furnishings; installation of equipment or machinery; or alteration of permanent structures, beyond that which would customarily be provided by an employer to all employes and which would normally be a component of the worksite.

(B) Engineering, architectural, ergonometric and other professional consultive services to determine the feasibility of, or design, worksite modifications.

(3) Premium relief. Premium relief provides the following assistance to the employer:

(a) The employer who hires a preferred worker will receive reimbursement of the premium for that worker for the first two years from the date of hire; and

(b) The employer shall not incur any increase in premium, or decrease in dividend otherwise due, as a result of an injury sustained by a preferred worker within two years after the date of hire.

(4) Obtained employment purchases. Obtained employment purchases are limited to those services and items an employer requires of a preferred worker as a condition of employment, or required for the worker to be able to accept the employment. This assistance is restricted to workers who are not eligible for vocational assistance under OAR 436-120, and are not receiving temporary total disability compensation. Obtained employment purchases are limited to the following:

(a) Tuition, books and fees for a class or course of instruction may be provided to meet the requirements of an obtained job. Payment is limited to $500 for this category.

(b) Tools and equipment required for obtained employment shall be limited to those items mandatory for initial employment, such as starter sets. Purchases shall not include what the employer would normally provide, what the worker possess; or, if provided in conjunction with worksite modification, duplicate items provided as part of such modification. Payment is limited to $1500 for this category.

(c) Clothing required as a condition of obtained employment. Purchases shall not include what the employer would provide. Payment is limited to $300 for this category.

(d) Moving expenses. Payment requires that the worker have obtained employment outside commuting distance.

Payment shall be limited to covering the cost of household goods weighing not more than 10,000 pounds and, if necessary, paying reasonable costs of meals and lodging for the worker's family. Payment for moving expenses, and mileage for one vehicle at $.21 per mile, is limited to a single one-way trip. In determining the necessity of paying moving expenses the department shall consider the possible availability of employment which does not require moving, or which requires less than the proposed moving distance.

(e) Rental allowance for primary residence. This allowance shall be limited to first and last month's rent, and requires the worker to have been required to move outside normal commuting distance to accept employment.

(f) Dues and fees of a labor union. Payment shall be limited to initiation fees, or back dues and one month's current dues, of a labor union which is the bargaining agent for the employment obtained by the worker.

Hist: Filed 2/20/87 as WCD Admin. Order 1-1987, eff. 3/16/87
Amended 12/17/87 as WCD Admin. Order 12-1987, eff. 1/1/88

End of Agreement Other Than by Completion

436-110-060 (1) If a reemployment assistance agreement is prematurely ended by the employer for reasons beyond the worker's control, the worker may be eligible for further assistance from the Workers' Reemployment Reserve with prior administrative approval.

(2) If a wage subsidy is interrupted for reasonable cause, it may be extended for a period equal to the length of interruption.

Hist: Filed 1/2/73 as WCB Admin. Order 1-1973, eff. 1/15/73
Amended 3/14/73 by WCB Admin. Order 3-1973, eff. 4/1/73
Amended 9/29/77 as WCD Admin. Order 2-1977 (Temp.), eff. 10/4/77
Amended 2/1/78 as WCD Admin. Order 2-1978, eff. 2/1/78
Amended 12/30/81 as WCD Admin. Order 7-1981, eff. 1/1/82
Renumbered from OAR 436-63-045, 5/1/85
Amended 2/20/87 as WCD Admin. Order 1-1987, eff. 3/16/87

Resolving Reemployment Assistance Disputes; Appeal to the Director

436-110-080 (1) If an employer, worker or insurer is aggrieved by a decision of the Section, the aggrieved party may request a review by the Director.

(2) Pursuant to ORS 656.622(2), the Director's decision shall be final and not subject to review by any court or other administrative body.

Hist: Filed 2/20/87 as WCD Admin. Order 1-1987, eff. 3/16/87
Amended 12/17/87 as WCD Admin. Order 12-1987, eff. 1/1/88

Filing of Agreements; Reimbursement of Reemployment Assistance Costs

436-110-090 (1) Reemployment assistance requests, agreements and supporting information shall be in the format prescribed by the Director.

(2) A Workers' Reemployment Reserve agreement shall be filed with the Department within ten days after obtaining the signatures of the parties, accompanied by the supporting information.

(3) The employer shall notify the department in writing when any agreement has been terminated by the employer prior to its originally scheduled completion date. Such notice shall be accompanied by the final reimbursement request.

(4) In the absence of the employer's or insurer's ability to pay, nothing in these rules precludes the department from advancing funds to enable the employer to perform a worksite modification or make an obtained employment purchase. In no case shall the department directly purchase or otherwise assume responsibility for worksite modifications or obtained employment purchases. Prior administrative approval is required in all such instances.

(5) The following procedures and conditions apply to reimbursing or advancing funds for costs of reemployment assistance:

(a) Reimbursement or advancement of funds shall be made only for reemployment assistance provided in accordance with these rules. Reimbursement under these rules shall not be made for vocational assistance under OAR 436-120.

(b) Reimbursement or advancement of funds will be made only after the agreement has been filed and approved. Requests for reimbursement or the advancement of funds shall be made in the manner prescribed by the Director.

(c) The Department will reimburse or advance funds for costs of reemployment assistance, subject to the availability of funds.

(d) Reemployment assistance costs must be paid before reimbursement is requested.

(e) Reimbursed costs shall not be charged by the insurer to the employer as claim costs or by any other means. Whenever reimbursement is denied, the insurer shall not change the costs of the reemployment assistance to the insured employer, worker or the new employer.

(f) Reimbursement requested before the employer has paid the costs is subject to denial or recovery by the Department. Insurers requesting reimbursement prior to paying the costs are subject to denial or recovery, in addition to any penalties under ORS chapter 656.

(g) Further procedures and conditions relating to reimbursement for worksite modification costs and obtained employment purchases are as follows:

(A) If the cost for a single item is over $1,000, three competitive quotes shall be obtained. If three quotes are not available, documentation of efforts to obtain three quotes shall be made (i.e., sole source). The lowest quote shall normally be selected.

(B) Multiple orders to circumvent the requirements of this section shall not be issued.

(h) Further procedures and conditions relating to premium relief are as follows:

(A) Employers shall submit quarterly requests for relief to the Compliance Section, Workers' Compensation Division, Department of Insurance and Finance in the form and format prescribed by the Director.

(B) Compliance Section will review the data submitted for accuracy and authorize reimbursement, subject to future audits.

(C) Reimbursement will be made equal to the standard premium of the employer based only on the payroll of their preferred workers.

(h) For wage subsidy and premium relief, employers and workers are required to certify payroll reimbursement and wages actually paid and received, as prescribed by the Director.

(6) If prior to the termination of a worksite modification agreement, the employer fails to meet any conditions prescribed for the care and protection of property in the employer's custody, and the property suffers damage or loss, the employer shall not be compensated for repair or replacement of the property.

(7) If prior to the termination of an agreement under these rules, the worker fails to adequately care for and protect property provided under OAR 436-110-035(4), and the property suffers damage or loss, the worker shall not be compensated for repair or replacement of the property.

Hist: Filed 2/20/87 as WCD Admin. Order 1-1987, eff. 3/16/87
Amended 12/17/87 as WCD Admin. Order 12-1987, eff. 1/1/88

Requirements of Insurers, Employers and Ratemaking Organizations Under Premium Relief

436-110-095 The following provisions apply to employers, the Department, insurers and ratemaking organizations licensed pursuant to ORS chapter 737, to provide premium relief under OAR 436-110-035(3):

(1) Total claims costs incurred as a result of any injury sustained by a preferred worker within two years after that worker is hired shall not be included in any process, calculation or report that could increase the employer's premium or premium rate, or decrease any dividend otherwise due the employer.

(2) Employers are responsible for notifying their insurers of the employment of each preferred worker for which they are receiving premium relief, and the duration of the preferred worker's status, by submitting a copy of the preferred worker agreement to the insurer. Notification shall be made at the time the employer applies for workers' compensation insurance or within 10 days of hiring a preferred worker where insurance is in effect at the time of hiring.

(2) In determining premium costs for a self-insured employer or employer on a retrospective rating plan, the Department shall simulate a premium for the preferred worker by using the published rates for self-insured employers and by using a standard insurance plan.

Hist: Filed 12/17/87 as WCD Admin. Order 12-1987, eff. 1/1/88

Audits

436-110-100 (1) Insurers and employers are subject to periodic program and fiscal audits by the Department. All reimbursements are subject to subsequent audits, and may be disallowed on any of the grounds set forth in these rules. Disallowed reimbursements may be recovered by the Department directly or from future reimbursements by way of offset. If the Department finds upon audit that procedures which led to disallowed reimbursements are still being used, the Department may withhold further reimbursements until corrections satisfactory to the Department are made.

(2) The insurer shall maintain case files, records, reports, receipts and canceled checks documenting reemployment assistance costs for which reimbursement has been requested by the insurer. These records shall be maintained in accordance with OAR 436-50 or for a period of three years after the last reimbursement request.

(3) The Department reserves the right to visit the worksite to determine compliance with the agreement under which reemployment assistance has been provided.

Hist: Filed 2/20/87 as WCD Admin. Order 1-1987, eff. 3/1/87
Amended 12/17/87 as WCD Admin. Order 12-1987, eff. 1/1/88

Sanctions

436-110-110 If the Director finds that a vocational assistance provider authorized pursuant to OAR 436-120 or an insurer misrepresented information in order to obtain reemployment assistance, or made a serious error or omission which results in Rehabilitation Review Section approving a Workers' Reemployment Reserve agreement, the Director may do one or both of the following:

(1) Order the insurer or vocational assistance provider to assume all or part of the financial obligation for the agreement;

(2) Prohibit an individual certified under OAR 436-120, a vocational assistance provider or an insurer from negotiating or arranging Workers' Reemployment Reserve agreements for such period the Director deems appropriate.

Hist: Filed 12/17/87 as WCD Admin. Order 12-1987, eff. 1/1/88

EXHIBIT "B"

BEFORE THE DIRECTOR OF THE DEPARTMENT OF INSURANCE AND FINANCE OF THE STATE OF OREGON

In the Matter of the Amendment of OAR Chapter 436, Workers' Compensation Division, Division 110, Assistance From the Workers' Reemployment Reserve	)))))	STATUTORY AUTHORITY, STATEMENT OF NEED, PRINCIPAL DOCUMENTS RELIED UPON AND STATEMENT OF FISCAL IMPACT

1. Citation of Statutory Authority: The statutory authority for promulgation of these rules is ORS 656.726(3) which authorizes the Director to make all rules reasonably required to administer, regulate and enforce ORS chapter 656; and, ORS 656.622(7), which authorizes the Director to make such rules as may be required to establish, regulate, manage and disburse the Workers' Reemployment Reserve.

2. Need for Amendment: The need for this amendment is to give reemployment assistance to Oregon employers who hire injured workers and to implement changes contained in House Bill 2900 enacted by the 1987 Legislative Session (chapter 884, Oregon Laws 1987).

3. Principal Documents Relied Upon: ORS chapter 656.

4. Fiscal and Economic Impact: Injured workers and employers who hire injured workers will receive assistance under this amendment. Workers not eligible for vocational assistance under OAR 436-120, may receive some help under this amendment.

Dated this 6 day of December, 1987.

Department of Insurance and Finance

Theodore R. Kulongoski, Director

VOCATIONAL ASSISTANCE TO INJURED WORKERS

Oregon Administrative Rules, Chapter 436

Division 120
Effective January 1, 1988

Department of Insurance and Finance
Workers' Compensation Division
Salem, Oregon 97310

**BEFORE THE DIRECTOR OF THE
DEPARTMENT OF INSURANCE AND FINANCE
OF THE STATE OF OREGON**

In the Matter of the Amendment of OAR Chapter 436, Workers' Compensation Division, Division 120, Vocational Assistance to Injured Workers	)))	ORDER OF ADOPTION

The Director of the Department of Insurance and Finance, pursuant to the rulemaking authority in ORS 656.726(3) and the procedure in ORS 183.335, amends OAR Chapter 436, Workers' Compensation Division, Division 120, Vocational Assistance to Injured Workers.

On October 20, 1987, the Department of Insurance and Finance filed a Notice of Proposed Amendment of Rules with the Secretary of State. The statement of Statutory Authority, Need, Principal Documents Relied Upon and Fiscal Impact was also filed with the Secretary of State.

Copies of the notice were mailed to interested persons in accordance with OAR 436-01-000 and to those on the Department's distribution mailing list as their interest indicated. The notice was published in the November 1, 1987, Bulletin of the Secretary of State.

On November 23, 1987, a public hearing was held as announced. The hearing was subsequently adjourned until December 3, 1987, to receive additional written testimony. A summary of the Testimony and Agency Responses is contained in Exhibit "C". This Exhibit is on file and available for public inspection between the hours of 8 a.m. and 5 p.m., normal working days Monday through Friday, in the Administrator's Office, Workers' Compensation Division, Department of Insurance and Finance, Room 200, Labor and Industries Building, Salem, Oregon 97310.

Having reviewed and considered the record of public hearing, and being fully advised, I make the following findings under the authority granted by ORS 656.726(3):

(1) The applicable statutes have been followed;
(2) The applicable rulemaking procedures have been followed;
(3) The rules are within the Director's authority; and
(4) After reviewing and considering data, views and arguments presented at the public hearing and in written testimony, the rules being adopted are reasonable and proper.

IT IS THEREFORE ORDERED:

(1) OAR Chapter 436, Division 120, Vocational Assistance to Injured Workers, as set forth in Exhibit "A" attached hereto, certified a true copy and hereby made a part of this order, be adopted this date, to be effective January 1, 1988.

(2) OAR 436-120-100, 436-120-110, 436-120-120, 436-120-130, 436-120-140 and 436-120-150 are repealed effective January 1, 1988.

(3) A certified true copy of the Order of Adoption and these rules, with Exhibit "B" consisting of the Citation of Statutory Authority, Statement of Need, Documents Relied Upon, and Statement of Fiscal Impact, attached and hereby made a part of this order, be filed with the Secretary of State.

(4) A copy of the Rules and attached Exhibit "B" be filed with the Legislative Counsel, pursuant to the provisions of ORS 183.715, within 10 days after filing with the Secretary of State.

Dated this 16th day of December, 1987

Department of Insurance and Finance

Theodore R. Kulongoski

Theodore R. Kulongoski, Director

EXHIBIT "A"

CHAPTER 436
DEPARTMENT OF INSURANCE AND FINANCE
WORKERS' COMPENSATION DIVISION
DIVISION 120

VOCATIONAL ASSISTANCE TO INJURED WORKERS

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OAR 436

DIVISION 120

VOCATIONAL ASSISTANCE TO INJURED WORKERS

Authority for Rules

436-120-001 (1) The Director has adopted OAR 436-120 by the Director's authority under ORS 656.340, ORS 656.726(3) and section 15, chapter 600, Oregon Laws 1985.

(2) An order of a division or section, issued under the Director's authority to administer ORS chapter 656 and rules adopted under that chapter, shall be considered an order of the Director.

Hist: Filed 12/30/73 as WCD Admin. Order 6-1973, eff. 1/11/74
Amended 11/5/74 as WCD Admin. Order 45-1974, eff. 11/5/74 (Temporary)
Amended 2/6/75 as WCD Admin. Order 4-1975, eff. 2/26/75
Amended 3/29/76 as WCD Admin. Order 1-1976, eff. 4/1/76
Amended 9/29/77 as WCD Admin. Order 3-1977, eff. 10/4/77 (Temporary)
Amended 2/1/78 as WCD Admin. Order 1-1978, eff. 2/1/78
Amended 5/22/80 as WCD Admin. Order 6-1980, eff. 6/1/80
Amended 12/29/82 as WCD Admin. Order 11-1982, eff. 1/1/83 (Temporary)
Amended 6/30/83 as WCD Admin. Order 2-1983, eff. 6/30/83
Amended 12/14/83 as WCD Admin. Order 5-1983, eff. 1/1/84
Renumbered from OAR 436-61-003, 5/1/85
Amended 12/12/85 as WCD Admin. Order 7-1985, eff. 1/1/86
Amended 12/17/87 as WCD Admin. Order 11-1987, eff. 1/1/88

Purpose of Rules

436-120-002 The purpose of these rules is to prescribe:

(1) The terms of eligibility for vocational assistance to workers with disabling compensable injuries, and the nature and extent of the assistance, pursuant to ORS 656.012(2)(c), 656.268(1) and 656.340;

(2) The standards, conditions and procedures for authorizing insurers and vocational rehabilitation organizations to be providers of vocational assistance, for certifying vocational assistance staff, and for suspending and revoking authorizations and certifications, pursuant to ORS 656.340;

(3) Fee schedules and conditions for payment by insurers for requested services of vocational assistance providers, pursuant to ORS 656.258 and 656.340;

(4) Recordkeeping and reporting requirements for insurers to assist the Department in monitoring their compliance with ORS 656.340;

(5) Procedures for resolving dissatisfaction of workers about vocational assistance actions, including procedures for the administrative review by the Director under ORS 656.283; and

(6) The terms of reimbursement to insurers for vocational assistance costs paid for injuries that were sustained prior to January 1, 1986, pursuant to section 15, chapter 600, Oregon Laws 1985.

Hist: Filed 12/29/82 as WCD Admin. Order 11-1982, eff. 1/1/83 (Temporary)
Filed 6/30/83 as WCD Admin. Order 2-1983, eff. 6/30/83
Amended 12/14/83 as WCD Admin. Order 5-1983, eff. 1/1/84
Renumbered from OAR 436-61-008, 5/1/85
Amended 12/12/85 as WCD Admin. Order 7-1985, eff. 1/1/86
Amended 12/17/87 as WCD Admin. Order 11-1987, eff. 1/1/88

Applicability of Rules

436-120-003 (1) These rules govern vocational assistance pursuant to the Workers' Compensation Law on and after January 1, 1988, except as these rules provide otherwise.

(2) Under these rules a claim for aggravation will be considered a new claim. However, a reference to "pre-1986 injuries" relates to injuries sustained before January 1, 1986, and encompasses both original claims and claims for aggravation of such injuries.

(3) Vocational assistance to a worker will be due at any given time with respect only to one claim of the worker. If a dispute arises about which claim gives rise to the need for vocational assistance pursuant to these rules, the Director will designate by an order under which claim vocational assistance is to be provided.

(4) All vocational assistance under these rules must be authorized by the insurer. Appeal of a decision by the insurer shall be made pursuant to ORS 656.283 and OAR 436-120-210.

(5) The Director may modify or waive provisions of these rules if the Director finds that necessary to carry out the provisions of ORS chapter 656.

Hist: Filed 3/29/76 as WCD Admin. Order 1-1976, eff. 4/1/76
Amended 9/26/77 as WCD Admin. Order 3-1977, eff. 10/4/77 (Temporary)
Amended 2/1/78 as WCD Admin. Order 1-1978, eff. 2/1/78
Amended 5/22/80 as WCD Admin. Order 6-1980, eff. 6/1/80
Amended 12/4/81 as WCD Admin. Order 4-1981, eff. 1/1/82
Amended 12/29/82 as WCD Admin. Order 11-1982, eff. 1/1/83 (Temporary)
Amended 6/30/83 as WCD Admin. Order 2-1983, eff. 6/30/83
Amended 12/14/83 as WCD Admin. Order 5-1983, eff. 1/1/84
Renumbered from OAR 436-61-004, 5/1/85
Amended 12/12/85 as WCD Admin. Order 7-1985, eff. 1/1/86
Amended 12/17/87 as WCD Admin. Order 11-1987, eff. 1/1/88

Objectives and Priorities of Vocational Assistance

436-120-004 (1) The objective of vocational assistance is to return the worker to employment which is as close as possible to the worker's regular employment at a wage as close as possible to the worker's wage at the time of injury.

(2) For workers determined eligible for vocational assistance under these rules, insurers are required to select the appropriate type of assistance required to accomplish the objective described in section (1). Selection of the type of assistance

most likely to return the worker to suitable employment must be made as soon as possible. The priorities to be considered in selecting the appropriate type of assistance are, in order:

(a) Return to suitable employment with the employer at the time of injury if that opportunity arises after the worker has been found eligible under OAR 436-120-040.

(b) Return to suitable employment with a new employer using direct employment services.

(c) Return to suitable employment using training services.

Hist: Filed 12/17/87 as WCD Admin. Order 11-1987, eff. 1/1/88

Definitions

436-120-005 Except where the context requires otherwise, the construction of these rules is governed by the definitions given in the Workers' Compensation Law and as follows:

(1) "Administrative approval" means an approval or finding in a particular matter by the administrator of the Workers' Compensation Division, or the administrator's delegate for the matter.

(2) "Department" means the Department of Insurance and Finance.

(3) "Director" means the director of the Department of Insurance and Finance or the Director's delegate for the matter.

(4) "Division" refers to the Workers' Compensation Division of the Department of Insurance and Finance.

(5) "Employer" means a subject employer, pursuant to ORS chapter 656; and, in the context of the job where an original claim or a claim for aggravation occurred, the person in whose employ the worker sustained the injury or made the claim for aggravation, respectively.

(6) "Employment" used with certain modifiers has the following meanings:

(a) "Suitable employment" means employment of the kind for which the worker has the necessary physical capacities, knowledge, transferable skills and abilities; located where the worker customarily worked, or within reasonable commuting distance of either the worker's residence at the time of claim or current residence.

(A) For the purpose of determining eligibility for vocational assistance, suitable employment includes a wage within 20% of the wage currently being paid for employment which is the regular employment for the worker.

(B) For the purpose of providing vocational assistance, the meaning of "suitable employment" also includes the objective that the employment provide a wage as close as possible to the wage currently being paid for the worker's regular employment. This wage may be considered suitable if not within 20% of the previous wage, if the wage is as close as possible to the previous wage. For other than full-time, permanent employment, suitable wage is determined as described in OAR 436-120-025.

(b) "Regular employment" means employment of the kind the worker held at the time of the injury or the claim for aggravation, whichever gave rise to the eligibility for vocational assistance; or, the worker's customary employment. "Customary employment" is the worker's regular employment when it is other than the job at injury, and is the primary means by which the worker earns a livelihood.

(7) "Insurer" means the State Accident Insurance Fund, an insurer authorized under ORS chapter 731 to transact workers' compensation insurance in Oregon, or a self insured employer. It also may include, except where the context requires otherwise, a vocational assistance provider with respect to any function the insurer requested the provider to perform. "The insurer" refers to whichever insurer has the worker's claim.

(8) "Return-to-work plan" means either the program of vocational assistance designed to result in the return to work of an injured worker, or the document which establishes and governs that program. A return-to-work plan may be either a "direct employment plan" or a "training plan."

(9) "Section" means the Rehabilitation Review Section of the Workers' Compensation Division of the Department of Insurance and Finance.

(10) "Substantial handicap to employment", for the purposes of determining eligibility for vocational assistance, means the worker, because of the injury, lacks the necessary physical capacities, knowledge, skills and abilities to be employed in suitable employment. "Knowledge", "skills" and "abilities" have meanings as follows:

(a) "Knowledge" means an organized body of factual or procedural information derived from the worker's education, training and experience.

(b) "Skills" means the demonstrated mental and physical proficiency to apply knowledge.

(c) "Abilities" means the mental and physical capability to apply the worker's knowledge and skills.

(11) "Transferable skills" means the knowledge and skills demonstrated in past training or employment which make a worker employable in suitable new employment. More general characteristics such as aptitudes or interests do not, by themselves, constitute transferable skills.

(12) "Vocational assistance" means any of the services, goods, allowances and temporary disability compensation under these rules for assisting in the return to work of an injured

worker. The term does not include activities for determining a worker's eligibility for vocational assistance.

(13) "Vocational assistance provider" means an insurer or other public or private organization authorized under these rules to provide vocational assistance to injured workers.

(14) "Worsened substantially", or a variation, means the worker, subsequent to becoming medically stationary, has an accepted aggravation claim.

Hist: Filed 8/30/66 as WCD Admin. Order 7-1966, eff. 8/30/66
Amended 12/20/73 as WCD Admin. Order 6-1973, eff. 1/11/74
Amended 11/5/74 as WCD Admin. Order 45-1974, eff. 11/5/74 (Temporary)
Amended 2/6/75 as WCD Admin. Order 4-1975, eff. 2/26/75
Amended 3/29/76 as WCD Admin. Order 1-1976, eff. 4/1/76
Amended 9/29/77 as WCD Admin. Order 3-1977, eff. 10/4/77 (Temporary)
Amended 2/1/78 as WCD Admin. Order 1-1978, eff. 2/1/78
Amended 5/22/80 as WCD Admin. Order 6-1980, eff. 6/1/80
Amended 12/4/81 as WCD Admin. Order 4-1981, eff. 1/1/82
Amended 12/29/82 as WCD Admin. Order 11-1982, eff. 1/1/83 (Temporary)
Amended 6/30/83 as WCD Admin. Order 2-1983, eff. 6/30/83
Amended 12/14/83 as WCD Admin. Order 5-1983, eff. 1/1/84
Renumbered from OAR 436-61-005, 5/1/85
Amended 12/12/85 as WCD Admin. Order 7-1985, eff. 1/1/86
Amended 12/17/87 as WCD Admin. Order 11-1987, eff. 1/1/88

Rehabilitation Review Section

436-120-010 The Rehabilitation Review Section is established within the Workers' Compensation Division of the Department of Insurance and Finance for the following principal purposes under these rules:

(1) Assuring that injured workers receive timely, appropriate and cost-effective vocational assistance pursuant to ORS 656.340 and these rules.

(2) Assisting to prevent or resolve dissatisfaction of workers about vocational assistance matters, and assisting in the administrative review by the Director under ORS 656.283(2).

(3) Providing for the authorization of vocational assistance providers and certification of individuals qualified to provide vocational assistance.

(4) Maintaining the integrity of the Department's reimbursement of vocational assistance costs paid by insurers for pre-1986 injuries.

Hist: Filed 12/14/83 as WCD Admin. Order 5-1983, eff. 1/1/84
Renumbered from OAR 436-61-017, 5/1/85
Amended 12/12/85 as WCD Admin. Order 7-1985, eff. 1/1/86
Amended 12/11/87 as WCD Admin. Order 11-1987, eff. 1/1/88

Reinstatement Rights; Responsibilities of Insurer and Worker

436-120-020 (1) The insurer shall inform a worker of the employment reinstatement rights and responsibilities of the worker under ORS chapter 659 and this rule, and of the insurer's responsibility under ORS 656.340 to make the reinstatement demand on behalf of the worker. This information shall be given:

(a) At the time of claim acceptance, per ORS 656.262(6);

(b) At the time of contact of the worker under OAR 436-120-035 about the need for vocational assistance, per ORS 656.340 (1); and

(c) Within five working days of receiving knowledge of the attending physician's release of the worker to return to work, per ORS 656.340(3).

(2) Subsection (1)(c) and section (3) of this rule apply only to workers with disabling compensable injuries who, because of the injury, have not returned to suitable employment.

(3) The insurer, within five working days of receiving knowledge of the attending physician's release, shall make demand on the employer for reinstatement or reemployment of the worker. This shall be considered a demand of the worker under ORS 659.415 and 659.420. To the extent possible under the insurer's knowledge of the release, the insurer shall make an effective demand in accordance with those statutes and the rules adopted thereunder by the Oregon Bureau of Labor and Industries.

(4) Nothing in this rule affects the responsibility of the attending physician under ORS 656.252(2) to advise the insurer and the worker, at the same time, within five days of the date the worker is released to return to work.

Hist: Filed 12/4/81 as WCD Admin. Order 4-1981, eff. 1/1/82
Amended 12/29/82 as WCD Admin. Order 11-1982, eff. 1/1/83 (Temporary)
Amended 6/30/83 as WCD Admin. Order 2-1983, eff. 6/30/83
Amended 12/14/83 as WCD Admin. Order 5-1983, eff. 1/1/84
Renumbered from OAR 436-61-050, 5/1/85
Amended 12/12/85 as WCD Admin. Order 7-1985, eff. 1/1/86
Amended 12/17/87 as WCD Admin. Order 11-1987, eff. 1/1/88

Establishing Base Wage to Determine Suitable Wage

436-120-025 (1) For the purpose of establishing a base wage from which to calculate a suitable wage when the worker's job at the time of injury is other than a full-time permanent job, the following standards apply:

(a) Volunteer employment. A volunteer's wage is the computed wage established to calculate temporary total disability payments and the employer's workers' compensation premium under OAR 436-60. When the worker's customary employment is other than the volunteer job, and the worker cannot return to that customary employment, the base wage is the computed wage calculated at a rate based on the time worked in the worker's customary employment.

(b) Seasonal and temporary employment. When the worker's customary employment pattern is periods of seasonal or temporary employment followed by periods in which unemployment insurance benefits are collected, the wage is established by including earned wages and unemployment insurance benefits for the 52 weeks preceding the injury. The combined income for the preceding 52 weeks is calculated at a full-time rate to establish the base wage.

(c) Part-time employment, two jobs. When the worker is employed in two part-time jobs and the worker is unable to

return to either job, the base wage is the wage rate with the employer at the time of injury, calculated at a rate based on the combined amount of time worked in both jobs.

(2) The Director may prescribe additional standards for establishing a base wage from which the wage described in OAR 436-120-005(6)(a) can be determined.

Hist: Filed 12/17/87 as WCD Admin. Order 11-1987, eff. 1/1/88

Likely Eligibility, Determining Eligibility and Contact of Worker

436-120-035 (1) The insurer shall determine if the worker is likely eligible for vocational assistance when one of the following occurs:

(a) The insurer receives a request for vocational assistance from the worker or the worker's authorized representative; or

(b) The insurer receives a medical report indicating a need for vocational assistance; or

(c) The worker has had 90 consecutive days of time loss.

(2) For likely eligibility to exist, the worker must have an accepted disabling claim or claim for aggravation; and the following information must be sufficient to indicate the worker will probably meet the eligibility criteria under OAR 436-120-040:

(a) A Report of Occupational Injury or Disease (Form 801) or medical report which indicates the severity of the injury; and

(b) A description of the duties, including physical demands, of the job at injury, and the types of jobs available at the employer at injury; and

(c) Information about the worker's work history and education.

(3) If the information required in section (2) is not available, the insurer shall obtain the information within 30 days of the occurrence of any one of the events in subsections (1)(a), (b) or (c) of this rule.

(4) If the worker is found likely eligible, the insurer shall contact the worker within five days of such finding to determine eligibility for vocational assistance.

(5) When the worker becomes medically stationary, if an eligibility determination has not previously been made, and the worker has not returned to regular employment or other suitable employment with the employer at the time of injury, the insurer must contact the worker within five days of learning the worker is medically stationary to determine eligibility for vocational assistance.

(6) As soon as possible, and not more than 30 days after the contact under sections (4) and (5) of this rule, the insurer shall determine whether the worker is eligible for vocational assistance. The individual making this determination for the insurer shall hold certification under OAR 436-120-205.

(7) An evaluation to determine if the worker has a substantial handicap to employment, using those services under OAR 436-120-075(1), shall be provided as part of the eligibility determination if the conditions under OAR 436-120-040(3)(a) and (b) have been satisfied, and a file review is not sufficient to determine if the worker has a substantial handicap to employment.

(8) Upon determining the worker is eligible the insurer and worker shall agree upon a vocational assistance provider pursuant to OAR 436-120-070 and cause vocational assistance to begin.

(9) If the worker has been determined ineligible, and the insurer subsequently receives knowledge of the worker's likely eligibility for vocational assistance, the insurer shall redetermine, by certified staff, whether the worker is eligible pursuant to the conditions in OAR 436-120-055.

Hist: Filed 12/29/82 as WCD Admin. Order 11-1982, eff. 1/1/83 (Temporary)
Filed 6/30/83 as WCD Admin. Order 2-1983, eff. 6/30/83
Amended 12/14/83 as WCD Admin. Order 5-1983, eff. 1/1/84
Renumbered from OAR 436-61-111, 5/1/85
Amended 12/12/85 as WCD Admin. Order 7-1985, eff. 1/1/86
Amended and Renumbered from OAR 436-120-060, 12/17/87 as WCD Admin. Order 11-1987, eff. 1/1/88

Eligibility for Vocational Assistance

436-120-040 A worker is eligible for vocational assistance when all of the following conditions have been met:

(1) The worker has sustained an accepted disabling compensable injury.

(2) There is medical evidence which indicates that, because of the injury, the worker will likely have a permanent disability; or, the worker has a Determination Order, Order of a Referee, Order on Review by the Workers' Compensation Board, decision of the Court of Appeals or an approved stipulation which grants permanent disability.

(3) As a result of the limitations caused by the injury, the worker:

(a) Is not able to return to regular work or other customary work;

(b) Is not able to return to any other suitable and available work with the employer; and

(c) Has a substantial handicap to employment and requires assistance to overcome that handicap.

(4) The worker is not limited by personal, psychological or physical problems which would materially interfere with the worker's ability to participate in or benefit from vocational assistance.

(5) The worker is authorized to work in the United States. Under OAR 436-120-055(2)(b), the insurer must redetermine eligibility if the worker subsequently obtains authorization to work in the United States.

(6) The worker is available in Oregon for vocational assistance.

(7) None of the conditions under OAR 436-120-050 for end of eligibility:

(a) Applies under the current opening of the claim;

(b) Has previously caused an end of eligibility under the current opening of the claim, except as provided under OAR 436-120-055; or

(c) Has previously caused an end of eligibility under a previous opening of the claim that reasonably still applies to the determination of eligibility under the current opening of the claim.

Hist: Filed 5/22/80 as WCD Admin. Order 6-1980, eff. 6/1/80
Amended 12/4/81 as WCD Admin. Order 4-1981, eff. 1/1/82
Amended 12/29/82 as WCD Admin. Order 11-1982, eff. 1/1/83 (Temporary)
Amended 6/30/83 as WCD Admin. Order 2-1983, eff. 6/30/83
Amended 12/14/83 as WCD Admin. Order 5-1983, eff. 1/1/84
Renumbered from OAR 436-61-100, 5/1/85
Amended 12/12/85 as WCD Admin. Order 7-1985, eff. 1/1/86
Amended 12/17/87 as WCD Admin. Order 11-1987, eff. 1/1/88

End of Eligibility for Vocational Assistance

436-120-050 The eligibility of a worker for vocational assistance ends when any of the following conditions have occurred:

(1) The worker's lack of suitable employment is no longer due to the disability caused by the injury. Under ORS 656.268(9), however, if the attending physician has approved the worker's return to employment and there is a labor dispute in progress at the place of employment, the refusal of the worker to return to that employment will not cause the loss of any vocational assistance available under these rules.

(2) The worker has been employed in suitable employment after the injury or claim for aggravation for 60 days. This provision shall not apply if the worker is not medically stationary, and further vocational assistance is required to overcome obstacles to the worker's continued employment.

(3) The worker's suitable employment after the injury or aggravation ended for a reason unrelated to the injury.

(4) The worker has refused an offer of suitable employment, or has failed to fully participate in available light-duty work intended to result in suitable employment.

(5) The worker has declined vocational assistance, has become unavailable in Oregon for vocational assistance, or has retired. This does not apply if the worker was compelled to accept early retirement, or a retirement settlement, and seek work elsewhere in lieu of accepting unsuitable employment.

(6) The worker has failed, after written warning, to fully participate in an evaluation of eligibility or a vocational evaluation required by the insurer, or to provide requested information which is material to such evaluations.

(7) The worker has failed, after written warning, to cooperate in the development of a return-to-work plan.

(8) The worker has failed, after written warning, to fully comply with the worker's responsibilities in a return-to-work plan under OAR 436-120-105.

(9) The worker has stopped attending training without notifying either the vocational assistance provider or the insurer.

(10) The worker's lack of suitable employment cannot be resolved by currently providing vocational assistance.

(11) The worker has misrepresented a matter which was material to the evaluation of eligibility or the provision of vocational assistance.

(12) The worker has been determined under ORS 656.268 to have no permanent disability. However, a subsequent stipulation that permanent disability exists will, unless its terms provide otherwise, rescind the end of eligibility under this section, and no interruption in eligibility will be considered to have occurred.

(13) The insurer has denied the claim under which the eligibility was determined.

(14) It is determined the worker is not authorized to work in the United States. Under OAR 436-120-055, the insurer must restore eligibility if the worker subsequently obtains authorization to work in the United States.

(15) The worker has refused to return property provided by the insurer under OAR 436-120-087, or reimburse the insurer, after the insurer has notified the worker of the repossession; or, the worker has misused funds provided for the purchase of property or services under OAR 436-120-087.

Hist: Filed 12/29/82 as WCD Admin. Order 11-1982, eff. 1/1/83 (Temporary)
Filed 6/30/83 as WCD Admin. Order 2-1983, eff. 6/30/83
Amended 12/14/83 as WCD Admin. Order 5-1983, eff. 1/1/84
Renumbered from OAR 436-61-126, 5/1/85
Amended 12/12/85 as WCD Admin. Order 7-1985, eff. 1/1/86
Amended and Renumbered from OAR 436-120-090, 12/17/87 as WCD Admin. Order 11-1987, eff. 1/1/88

Restoring and Redetermining Eligibility for Vocational Assistance

436-120-055 (1) The insurer may restore the eligibility of a worker if the circumstances which caused the end of eligibility of a worker under OAR 436-120-050(5) or (10) had a reason-

able cause but have changed so that there would no longer be a cause for such an ending of eligibility. At any time, the insurer may restore the worker's eligibility if it has determined the original decision to end eligibility to have been made in error. No interruption in eligibility will be considered to have occurred.

(2) The insurer shall redetermine eligibility for a worker previously determined ineligible only under the following conditions:

(a) It was previously determined that the worker could not benefit from vocational assistance because of physical, psychological or other personal problems, and those conditions have changed so that the worker can now benefit from assistance;

(b) It was previously determined that the worker was not authorized to work in the United States, and the worker has subsequently obtained such authorization.

(c) The worker, for good cause, was not available or had declined vocational assistance and is now able to participate;

(d) The insurer had erred in its previous eligibility determination;

(e) The worker's physical condition has substantially worsened, if the worker was medically stationary at the time of the latest eligibility determination; or

(f) The worker had returned to work on the basis of the physician's trial work release and the job was unsuitable.

(3) Except as provided in section (1) of this rule, a worker will not again become eligible, under the current opening of a claim, after eligibility has once ended under OAR 436-120-050.

Hist: Filed 12/12/85 as WCD Admin. Order 7-1985, eff. 1/1/86
Amended and Renumbered from OAR 436-120-095, 12/17/87 as WCD Admin. Order 11-1987, eff. 1/1/88

Selection of Vocational Assistance Provider

436-120-070 (1) The insurer shall select an individual certified under OAR 436-120-205 to determine whether the worker is eligible for vocational assistance. The insurer may make such an evaluation by use of its own certified staff, or may assign the worker to a vocational assistance provider holding authorization under OAR 436-120-200.

(2) For a worker determined eligible for vocational assistance under OAR 436-120-040, the insurer and worker shall agree on the selection of a vocational assistance provider. If they are unable to agree, the insurer shall notify the Rehabilitation Review Section immediately. The Section will attempt to resolve the dispute in accordance with the provisions of OAR 436-120-210. If agreement is not reached, the Director shall select the provider. Such selections are at the sole discretion of the Director. In making such selections the Director may consider, but is not limited to, any or all of the following criteria:

(a) The performance of the provider in returning workers to suitable employment.

(b) The ability of the provider to meet any special needs of the worker.

(c) The cost of the provider's services.

(d) The performance of the provider in developing return-to-work plans which conform to these rules.

(e) The geographic proximity of the provider to the worker.

(3) Any change in the selection of vocational assistance provider must be agreed to by the worker and insurer, and is subject to the approval of the Director.

(4) Immediately upon suspension or revocation of the authorization of a vocational assistance provider under OAR 436-120-203, the insurer shall reassign the affected worker to another authorized provider.

(5) In accordance with ORS 656.258, if the insurer assigns a worker to a vocational assistance provider for vocational assistance services or determining the worker's eligibility for vocational assistance, the insurer shall pay, within 60 days of receipt, the provider's billings duly rendered under the agreement between the insurer and the provider. The insurer shall not deny payment on the grounds that the worker was not eligible for the assistance, if the provider performed the services in good faith without knowledge of the ineligibility.

Hist: Filed 5/22/80 as WCD Admin. Order 6-1980, eff. 6/1/80
Amended 12/4/81 as WCD Admin. Order 4-1981, eff. 1/1/82
Amended 12/29/82 as WCD Admin. Order 11-1982, eff. 1/1/83 (Temporary)
Amended 6/30/83 as WCD Admin. Order 2-1983, eff. 6/30/83
Amended 12/14/83 as WCD Admin. Order 5-1983, eff. 1/1/84
Renumbered from OAR 436-61-120, 5/1/85
Amended 12/12/85 as WCD Admin. Order 7-1985, eff. 1/1/86
Amended 12/17/87 as WCD Admin. Order 11-1987, eff. 1/1/88

Kinds of Vocational Assistance

436-120-075 The following kinds of vocational assistance are available under the terms of these rules:

(1) Vocational evaluation. A vocational evaluation shall be provided if the insurer determines from a review of the existing file information and contacts with the worker, employers and physicians, or any of these, that the existing information is insufficient to determine the nature and extent of vocational assistance needed by the worker to obtain suitable new employment. A vocational evaluation includes any one or more of the following services:

(a) Vocational testing. Vocational testing is used to measure intelligence, aptitudes, achievements, abilities, interests and personality, by using standard and generally accepted measures.

(b) Work evaluation. Work evaluation is the use of standardized work samples, psychometric and other vocational

tests, in a systematic and comprehensive process to determine a worker's vocational abilities and needs, and the interpretive report which documents the results and meaning of the evaluation.

(c) On-the-job evaluation. On-the-job evaluation is provided to evaluate a worker's work traits, aptitudes, limitations, potentials and habits in an actual job experience.

(d) Other similar evaluations.

(e) Job analysis. Job analysis is the detailed description, or making the description, of the demands, physical and otherwise, of a job or occupational goal.

(f) Labor market survey. Labor market survey is the information compiled, or the compiling activity, to determine the wages and availability of suitable employment, currently or expected at a future time, obtained from direct contact with employers, others having actual labor market information or from other recently completed surveys of this kind.

(2) Direct employment plan. A direct employment plan assists a worker to obtain suitable new employment, with the help of one or more direct employment services as follows:

(a) Employment counseling.

(b) Job search skills instruction. Job search skills instruction is used to teach workers how to write resumes, locate suitable new employment, complete employment applications, interview for employment and other skills related to looking for suitable new employment.

(c) Job development. Job development is locating, or assisting the worker to locate prospective employers, and assisting the worker in related return-to-work activity.

(d) Return-to-work follow-up. Return-to-work follow-up is contacting a worker and employer after the worker returns to work to determine if the worker needs further assistance, while the worker remains eligible, to help continue the employment.

(e) Labor market survey.

(f) Job analysis.

(g) Other services of a direct employment nature. For pre-1986 injuries, administrative approval is required.

(3) Training plan. A training plan assists a worker to obtain suitable employment and consists of one or more of the kinds of training described in this section, together with plan development, progress monitoring and, as necessary, one or more of the direct employment services under section (2) of this rule. The kinds of training are as follows:

(a) On-the-job training. This is a wage-paying job furnishing instruction in job skills to qualify the worker for the continuation of permanent, suitable employment with the employer providing the job and the training. During the training the wages are subsidized as specified by a contract between the employer and the insurer, and the temporary disability compensation payable to the worker is reduced as provided in ORS 656.212.

(b) Skills training. This teaches the worker job skills in a self-contained program under the auspices of a community college, but with the training site at the location of an employer who teaches the skills on behalf of the college.

(c) Sheltered workshop training. This is provided in a facility established and operated to provide evaluation, training and employment for severely disabled individuals.

(d) Basic education. This raises the worker's relatively low level of education so the worker can obtain suitable employment directly or through participation in other training.

(e) Formal training. This teaches the worker job skills in a vocational school, community college or other post-secondary educational facility.

(f) Other services of a training nature. For pre-1986 injuries, administrative approval that the services provide necessary training assistance is required.

(4) Direct worker purchases. The goods, services and allowances described in OAR 436-120-087 may be provided by the insurer to the worker in conjunction with the plans and services under these rules, or to meet the requirements of obtained employment.

Hist: Filed 12/29/82 as WCD Admin. Order 11-1982, eff. 1/1/83 (Temporary)
Filed 6/30/83 as WCD Admin. Order 2-1983, eff. 6/30/83
Amended 12/14/83 as WCD Admin. Order 5-1983, eff. 1/1/84
Renumbered from OAR 436-61-060, 5/1/85
Amended 12/12/85 as WCD Admin. Order 7-1985, eff. 1/1/86
Amended and Renumbered from OAR 436-120-030, 12/17/87 as WCD Admin. Order 11-1987, eff. 1/1/88

Vocational Evaluation

436-120-080 (1) Vocational evaluations shall incorporate, and not duplicate, information derived from an evaluation to determine whether the worker has a substantial obstacle to employment.

(2) Vocational testing. Any test used must have a sufficient level of validity and reliability for the population which includes the worker. The reporting of test results shall include any applicable cautions relating to the reliability and validity of the results.

(3) On-the-job evaluation. On-the-job evaluation is subject to all of the following conditions:

(a) The job experience is primarily for the worker's benefit;

(b) The job experience will not necessarily result in a permanent job with the cooperating employer;

(c) The employer does not expect a substantial gain from the worker's activity; and

(d) The worker does not displace another worker.

Hist: Filed 12/17/87 as WCD Admin. Order 11-1987, eff. 1/1/88

Direct Employment

436-120-083 (1) The insurer shall develop a direct employment plan for an eligible worker when the insurer finds one or more direct employment services under OAR 436-120-075 sufficient to enable the worker to obtain suitable new employment. A finding that a direct employment plan is sufficient also requires a finding that the worker has the necessary transferable skills for the new employment.

(2) The insurer shall provide return-to-work follow-up during the first 60 days after the worker becomes employed, while direct employment services are available under section (4) of this rule, and for as long as the insurer finds necessary to help continue the employment while the worker remains eligible.

(3) Direct employment services shall not be provided to a worker after the insurer has found that the obstacle to obtaining suitable employment is the condition of the labor market rather than the worker's disability. This can only be found by establishing that:

(a) The worker's permanent limitations have been defined, as evidenced by a determination under ORS 656.268 or otherwise;

(b) The worker has adequate job search skills; and

(c) Positions of suitable employment exist in a reasonable quantity, and are likely to remain so, regardless whether the positions are currently available.

(4) Except as provided in section (5) of this rule, direct employment services shall not be provided to a worker after four months from the earliest Determination Order, Opinion and Order of a Referee, Order on Review by the Board, decision of the Court of Appeals or stipulation which grants or continues a permanent disability award after the latest opening of the worker's claim. However, if there has been no previous eligibility under that claim opening, the four months will start to run upon the insurer's determining that the worker is eligible.

(5) Section (4) of this rule does not apply to labor market surveys or job analyses as part of an eligibility evaluation, vocational evaluation, or to return-to-work follow-up during the first 60 days after the worker becomes employed. Direct employment services may be available beyond the expiration date under section (4) if circumstances caused the worker to receive less than the normal extent of services and to need further services. For pre-1986 injuries such additional services require administrative approval.

(6) Vocational assistance costs during direct employment services are subject to the conditions under OAR 436-120-087, 215 and 220.

(7) The insurer may provide other services of a direct employment nature not described in these rules. For pre-1986 injuries, administrative approval is required.

Hist: Filed 12/17/87 as WCD Admin. Order 11-1987, eff. 1/1/88

Training

436-120-085 (1) The insurer shall develop a training plan for an eligible worker only when the insurer finds that a direct employment plan is not sufficient for the worker to obtain suitable new employment, other than by reason of the condition of the labor market; and, the worker, only with the training provided under section (2), can return to employment which pays a wage significantly closer to the wage at the time of injury. "Significantly closer" may vary depending on several factors, including the worker's wage at injury.

(2) Training of any and all kinds is limited to an aggregate duration of 16 months, subject to extension to 21 months by the Director for a worker with an exceptional disability. An "exceptional disability" means the complete loss, or loss of use, of two or more limbs. Such extent of disability shall be the standard for determining whether other disabilities are exceptional under this section.

(3) A worker enrolled and actively engaged in training shall receive temporary total disability compensation subject to the limits in section (1). At the insurer's discretion, training costs may be paid for periods longer than 21 months, but in no event shall temporary total disability compensation be paid for a period longer than 21 months. Temporary total disability compensation and vocational assistance costs during training are also subject to the conditions under OAR 436-120-087, 215, 220, 230 and 250.

(4) The selection of the plan objectives and kind of training shall attempt to minimize the length and cost of training necessary to prepare the worker for suitable employment.

(5) The insurer shall not provide any further training to a worker who has completed one training plan, unless the worker's physical condition has worsened substantially so as to render the worker incapable of obtaining suitable employment; or, the previous plan is inadequate to prepare the worker for suitable employment because of an error or omission by the insurer.

(6) On-the-job training shall be the first option considered in developing a training plan. If on-the-job training is not possible, skills training shall be considered before formal training.

(7) Basic education is limited to a duration of six months. It is normally provided as part of a plan in conjunction with on-the-job training, skills training or formal training.

(8) On-the-job training and skills training are limited to a duration of 12 months.

(9) Skills training is subject to the following conditions:

(a) The employer makes no guarantee of employing the worker when the training is completed;

(b) The worker does not displace another worker;

(c) No wage is paid to the worker;

(d) The employer does not expect a substantial gain from the worker;

(e) The activity is primarily for the worker's benefit; and

(f) The employer has a sufficient number of employes to accomplish the regular work of the employer and the training of the worker.

(10) Training shall end if any of the following applies:

(a) The work which is the vocational objective could not be performed adequately by the worker as documented by a physical capacities evaluation.

(b) The worker's performance in the training falls below the level which is satisfactory to obtain employment in the field which is the vocational objective. In an academic program, failure for two consecutive grading periods to maintain at least a 2.00 cumulative grade point average, or failure for two grading periods to complete the minimum credit hours required under the training plan, is prima facie evidence of unsatisfactory performance. The worker shall be given written warning of the possible end of training at the end of the first grading period of unsatisfactory performance.

(c) The worker has failed to cooperate in meeting the requirements of the training plan.

(d) The worker is not enrolled and actively engaged in the training. However, none of the following will be considered as ending the worker's training status:

(A) A regularly scheduled break of not more than six weeks between fixed school terms.

(B) A break of not more than two weeks between the end of one kind of training and the start of another, such as on-the-job training, for which the starting date is flexible.

(C) A period of illness or recuperation which does not prevent completion of the training by the planned date.

(e) The worker has obtained suitable employment.

(f) Any of the conditions under OAR 436-120-050 for ending eligibility applies.

Hist: Filed 12/17/87 as WCD Admin. Order 11-1987, eff. 1/1/88

Direct Worker Purchases

436-120-087 (1) Direct worker purchases shall be provided as necessary for the worker's participation in vocational assistance; as necessary elements of evaluation, direct employment or training services; and, as necessary to meet the requirements of an obtained job. The insurer shall provide direct worker purchases under the conditions and limitations in this rule. In determining the necessity of such purchases, the insurer shall consider, among all factors, the worker's pre-injury net income as compared with the worker's post-injury net income. Except for purchases under subsections (2)(a) and (c) of this rule, the worker's pre-injury net income must be found greater than the worker's post-injury net income, to find the purchase necessary. Permanent partial disability award payments shall not be considered as income under this rule. The worker shall provide the information reasonably requested for determining necessity.

(2) Direct worker purchases include partial purchase, lease, rental and payment. For pre-1986 injuries, OAR 436-120-220 prescribes further conditions for some purchases over $1,000. The conditions and limits for direct worker purchases are as follows:

(a) Tuition, fees, books and supplies for training or studies. The items shall have been identified as mandatory by the instructional facility, trainer or employer, and shall pertain to the following:

(A) Training.

(B) A class necessary to meet the requirements of an available job.

(C) Vocational or academic studies, or basic education, for a worker not medically stationary, to enable earlier return to work of a worker not needing training, or earlier completion of training of a worker not yet capable of fully participating in training.

(b) Travel expenses for transportation, meals and lodging required for participation in vocational assistance. The conditions and rates for payment of travel expenses are as follows:

(A) Transportation. Costs shall be paid at public transportation rates when public transportation is available. Otherwise, private car mileage for reasonable distances shall be paid at $.21 per mile. Mileage payment in conjunction with moving expenses shall be allowed only for one vehicle and for a single one-way trip. Costs incidental to the private vehicle mileage, such as parking fees, also shall be paid. For workers receiving temporary total disability, transportation costs shall be paid only for those costs in excess of what the worker paid for transportation at the time of injury.

(B) Meals, non-overnight travel. Actual meal costs up to a total of $10 shall be paid for a day during which the worker was away from home for at least 10 hours.

(C) Meals and lodging, overnight travel. For overnight travel, meal and lodging expense will be reimbursed under a 24-hour allowance system. The total allowance, with receipts for commercial lodging, is $46 for a 24-hour period of travel, increased or decreased by $1 for each hour of travel more or less than the 24-hour period. The adjustment will be based on the number of hours after rounding to the nearest whole number.

(D) Special travel costs. Payment shall be made in excess of the amounts specified in paragraphs (A), (B) and (C) of this subsection when special transportation or lodging is necessary because of the physical needs of the worker, or when the insurer finds that prevailing costs in the travel area are substantially higher than average.

(c) Tools and equipment for training or obtained employment. The items shall be limited to those which are mandatory for the training or initial employment, such as starter sets. Purchases shall not include what the trainer or employer ordinarily would provide to all employes or trainees in the training or employment, what the worker possesses or, in the case of obtained employment, what the worker could reasonably be expected to provide.

(d) Clothing required for participation in vocational assistance or for obtained employment. Purchases shall not include what the trainer or employer would provide. In determining whether a purchase is necessary, the insurer shall consider the clothing the worker possesses. Purchases for training shall be limited to specialized clothing not possessed by the worker.

(e) Moving expenses. Payment requires that the worker have obtained employment outside reasonable commuting distance, or that moving is the most feasible and economical way for the worker to participate in training. Payment shall be limited to covering the moving of household goods weighing in total not more than 10,000 pounds and, if necessary, paying reasonable costs of meals and lodging for the worker's family. In determining the necessity of paying moving expenses the insurer shall consider the availability of employment which does not require moving, or which requires less than the proposed moving distance. The insurer shall inform the worker that payment for moving expenses is limited to a single one-way trip, unless an exception is made for unusual circumstances. For pre-1986 injuries the exception requires administrative approval.

(f) Second residence allowance. The purpose of the second residence must be to enable the worker to participate in training outside reasonable commuting distance. The allowance shall equal the rental expense reasonably necessary, plus not more than $100 per month toward all other expenses of the second residence, excluding refundable deposits, which are in addition to the continuing expenses of the primary residence.

(g) Primary residence allowance. This allowance shall be limited to first and last months' rent, and requires the worker to have changed residence for training or obtained employment.

(h) Medical examinations and psychological examinations. Payment requires that these be for conditions not related to the compensable injury and only for determining the worker's ability to participate in vocational assistance.

(i) Physical capacities evaluation. Physical capacities evaluation is the objective assessment, directly observed, measuring the worker's ability to perform a variety of physical tasks combined with statements of the worker's abilities by the worker and the evaluator. Physical tolerance screening, Blankenship's Functional Evaluation, functional capacity assessment and work tolerance screening shall be considered as having the same meaning. Physical capacities evaluations are used to determine whether the worker can perform a specific job or whether a particular vocational goal is within the worker's physical capacities.

(j) Dental work, eyeglasses, hearing aids and prosthetic devices. Payment requires that these be for conditions not related to the compensable injury and for enabling the worker to obtain suitable employment.

(k) Dues and fees of a labor union. Payment shall be limited to initiation fees, or back dues and one month's current dues, of a labor union which is the bargaining agent for the employment obtained by the worker.

(l) Vehicle rental or lease. This requires that there be no reasonable alternative for enabling the worker to participate in vocational assistance or accept an available job, and the that the worker is not receiving temporary total disability compensation or equivalent income. The cost under this category is limited to $1,000.

(m) Child and disabled adult care services. These are payable at rates not exceeding the prevailing rates, if the services are required to enable the worker to participate in vocational assistance. For workers receiving temporary total disability compensation or equivalent income, these costs shall be paid only when in excess of what the worker paid for such services at the time of injury, and where such costs result from a change in the worker's schedule at the time of injury.

(n) Living expense allowance during vocational evaluation. This allowance requires that the worker be involved in a vocational evaluation at least five hours daily for four or more consecutive days, and not be receiving temporary disability payments or equivalent income. The allowance shall not exceed what the worker would receive for temporary total disability if the worker's claim were reopened.

(o) Work adjustment cost. Payment is limited to covering necessary work adjustment activity for up to eight weeks.

(p) Any other direct worker purchase the insurer considers necessary under the standards of section (1) of this rule. Payment is limited to $500 for this category.

(3) Administrative approvals under this rule will be based on

whether the purchases are necessary under the standards of section (1) of this rule, and such other limits as may be established by the Director. The insurer's request for administrative approval shall be accompanied by information showing such necessity.

(4) Direct worker purchases shall not include purchases of real property, payment of fines or other penalties, or payment of additional driver's license costs or any other costs attributable to problems with the worker's driving record.

Hist: Filed 12/17/87 as WCD Admin. Order 11-1987, eff. 1/1/88

Return-to-Work Plans and Plan Support

436-120-105 (1) Return-to-work plans shall be in the form and format prescribed by the Director.

(2) Return-to-work plan support shall contain all of the following:

(a) A description of the worker's current medical condition, relating the worker's limitations to the vocational objectives.

(b) A description of the worker's education and work history, including job durations, wages and specific job duties.

(c) If a direct employment plan, a description of the worker's transferable skills which relate to the vocational objectives. If a training plan, why direct employment services are not sufficient to return the worker to suitable employment.

(d) A summary of the results of any vocational evaluations which relate to the vocational objectives.

(e) A summary of labor market information which supports the vocational objectives, and documents that the worker has been informed of the condition of the labor market. If the labor market does not support the vocational objectives, the insurer shall explain why the objectives remain the goal for the worker.

(3) Training plan support shall contain a job analysis made by the vocational assistance provider, signed by the provider or treating physician, and based on a visit to a worksite comparable to what the worker could expect at the completion of training.

(4) If, in the development or implementation of a return-to-work plan, there appears the likelihood of suitable employment with the employer, plan development or efforts to obtain new employment shall cease. The insurer shall then provide services with the objective of returning the worker to the employer until suitable employment with a new employer appears more feasible. If the worker is actively engaged in training, training shall not cease until and unless the insurer is certain the job is suitable employment.

Hist: Filed 12/17/87 as WCD Admin. Order 11-1987, eff. 1/1/88

Return-to-Work Plans; Responsibilities of the Worker and the Provider

436-120-115 Workers and vocational assistance providers have the following responsibilities in connection with return-to-work plans:

(1) The worker shall maintain contact with the vocational assistance provider as required in the plan, and fully participate in plan services.

(2) In addition to the requirements in OAR 436-120-085(10), workers in training plans have the following responsibilities:

(a) In formal training, the worker shall take the maximum courseload consistent with the worker's capabilities. This shall be at least 15 credit hours per term or nine hours per summer term, or the equivalent courseload at the particular training facility. Twelve credit hours will be an acceptable courseload for one term if the worker has reduced capabilities because of medical problems, prolonged time since last attending school or need of remedial education. To the extent feasible the courses shall relate to the vocational objective.

(b) The worker shall provide specific training and grade reports as required by the insurer or section (3) of this rule.

(3) For pre-1986 injuries the worker and vocational assistance provider shall have the following additional responsibilities:

(a) The worker shall provide to the vocational assistance provider, by the fifth day of each month, a written training report about the previous month which documents attendance, training progress, and problems or special needs.

(b) The worker shall forward each grade report to the vocational assistance provider within 10 days of the worker's receipt of the report.

(c) The vocational assistance provider shall visit each training site to establish the curriculum and assist the worker in enrollment. The provider shall contact the worker, trainers and training facility counselors to the extent necessary to assure the worker's participation and progress in the training meet the requirements of these rules and is satisfactory to achieve the training plan objective. If the training site is outside Oregon or is otherwise not reasonably accessible, telephone contact should be used. If the vocational assistance provider fails to reasonably verify the worker's participation and progress in accordance with this subsection and additional costs thereby result, the insurer or provider may be required to bear the additional costs, including additional costs under OAR 436-120-250(4).

Hist: Filed 12/17/87 as WCD Admin. Order 11-1987, eff. 1/1/88

Notices to Worker, Attorney and Department

436-120-160 (1) The insurer shall notify a worker in writing, by means of the return-to-work plan or otherwise, whenever the insurer:

(a) Determines the worker is not likely eligible under OAR 436-120-035, if this determination was initiated by the worker's request for vocational assistance.

(b) Determines under OAR 436-120-040 that the worker is eligible or ineligible for vocational assistance. However, no notice of ineligibility is required if the worker was determined ineligible because of return to regular or other suitable employment with the employer. Every notice of ineligibility shall notify the worker of possible assistance available at no cost from the Employment Division or the Vocational Rehabilitation Division. Such notice shall also inform the worker that the insurer shall send the list of vocational assistance providers authorized under OAR 436-120-200 upon the worker's request.

(c) Reaches agreement with an eligible worker on the initial selection of a vocational assistance provider; or, any agreement to change the provider.

(d) Denies particular or further vocational assistance, and the worker then indicates dissatisfaction about the nature or extent of vocational assistance which will be provided.

(e) Ends training, whether or not the insurer anticipates resumption of training.

(f) Ends eligibility for vocational assistance.

(2) Warning notices required under OAR 436-120-050 and 085(10) shall state the reason, the relevant and material rules and, if applicable, the corrective action needed within a specified time to avoid the ending of vocational assistance.

(3) Every notice stating the worker's ineligibility for vocational assistance, denying particular or further vocational assistance, or ending eligibility for vocational assistance, shall contain a brief explanation of the decision, a citation of the relevant and material rules, and an explanation of the worker's appeal rights. The equivalent of the following shall be used to explain the appeal rights: "If you disagree with this decision, you should contact (use appropriate reference to the insurer). If you remain dissatisfied you should contact Rehabilitation Review Section, Workers' Compensation Division, Department of Insurance and Finance, (use appropriate mailing address). This contact must be made within 60 days of receiving this letter or you will lose your right to appeal this decision." Pursuant to ORS 656.331(1)(b), copies of such notices shall be sent simultaneously to the worker's attorney.

(4) Every notice shall be dated and shall state the effective date of the action of which notice is given.

(5) The insurer shall give the same written notice to the Department as to the worker, unless the Director prescribes otherwise. The Director will also prescribe the time and place for giving the notice to the Department.

(6) The Director may prescribe other specific contents for the notices required under this rule.

Hist: Filed 12/29/82 as WCD Admin. Order 11-1982, eff. 1/1/83 (Temporary)
Filed 6/30/83 as WCD Admin. Order 2-1983, eff. 6/30/83
Amended 12/14/83 as WCD Admin. Order 5-1983, eff. 1/1/84
Renumbered from OAR 436-61-171, 5/1/85
Amended 12/12/85 as WCD Admin. Order 7-1985, eff. 1/1/86
Amended 12/17/87 as WCD Admin. Order 11-1987, eff. 1/1/88

Filing of Status Report, Return-to-Work Plan and Supporting Information; Review

436-120-170 (1) The insurer shall file a status report with Rehabilitation Review Section for each worker whom the insurer was required under OAR 436-120-035 to contact to determine eligibility for vocational assistance. The report shall provide information about the determination of vocational assistance eligibility and the development of a return-to-work plan, and other information prescribed by the Director. The insurer shall make the filing as indicated for the first to occur of the following:

(a) The development of a return-to-work plan, or the completed negotiation of an agreement under the Workers' Reemployment Reserve rules. The filing shall be within ten days after the signing of, and shall be accompanied by, the plan or contract.

(b) The 135th day after the date of injury or claim for aggravation. The filing shall be no later than that 135th day.

(c) For a pre-1986 injury, the submission of the insurer's first reimbursement request under the claim. The filing shall accompany the request.

(2) The insurer shall make subsequent filings of status reports as prescribed by the Director.

(3) The insurer shall complete development of a return-to-work plan no later than:

(a) Two months after the determination of eligibility under OAR 436-120-035 if the worker was medically stationary at the time of such determination; or

(b) Four months after the determination of eligibility under OAR 436-120-035 if the worker was not medically stationary at the time of such determination.

(4) The insurer shall file the plan with Rehabilitation Review Section within ten days after completion.

(5) If the plan is subsequently changed with respect to vocational objective or kind of vocational assistance, the insurer shall file the amended plan with Rehabilitation Review Section within ten days after completing the development of the amended plan. Related vocational objectives developed in the

course of a direct employment plan will not require filing of an amended plan.

(6) Unless the Director prescribes otherwise, and so notifies the insurer, an insurer shall include with its filings of return-to-work plans the supporting information for the plan. In determining whether a particular insurer will not be required to file the supporting information, the Director will consider the Department's findings on conformance to these rules of previous plan and plan support filings of the insurer or the insurer group with which the insurer is affiliated.

(7) To the extent the Director considers necessary, Rehabilitation Review Section will review return-to-work plans and the supporting information for conformance to these rules. If the Section notifies an insurer that a plan or its supporting information does not conform to these rules, the insurer shall respond with appropriate changes or reasons why no change should be made.

Hist: Filed 12/14/83 as WCD Admin. Order 5-1983, eff. 1/1/84
Renumbered from OAR 436-61-172, 5/1/85
Amended 12/12/85 as WCD Admin. Order 7-1985, eff. 1/1/86
Amended 12/17/87 as WCD Admin. Order 11-1987, eff. 1/1/88

Informing Worker of Rights and Responsibilities

436-120-180 (1) The insurer shall inform a worker, at the indicated times, of the following matters:

(a) The worker's rights and responsibilities, and the procedures for resolving any dissatisfaction of the worker with an action of the insurer or the Department, regarding vocational assistance. Such information shall include the worker's participation in the selection of a vocational assistance provider. This information shall be given no later than the time the insurer informs the worker of the eligibility determination.

(b) Employment reinstatement matters, as provided under OAR 436-120-020.

(c) The assistance available to employers and workers from the Workers' Reemployment Reserve. This information shall be given at the time of acceptance of the claim or claim for aggravation; upon release for work by the attending physician, pursuant to ORS 656.340(3); and, upon contact of the worker by the insurer pursuant to ORS 656.340(2).

(2) The Director may prescribe, as the means for satisfying some or all of the requirements of this rule, that the insurer furnish workers with specified written material at specified times.

Hist: Filed 12/29/82 as WCD Admin. Order 11-1982, eff. 1/1/83 (Temporary)
Filed 6/30/83 as WCD Admin. Order 2-1983, eff. 6/30/83
Amended 12/14/83 as WCD Admin. Order 5-1983, eff. 1/1/84
Amended 4/4/84 as WCD Admin. Order 3-1984, eff. 4/4/84
Renumbered from OAR 436-61-174, 5/1/85
Amended 12/12/85 as WCD Admin. Order 7-1985, eff. 1/1/86
Amended 12/17/87 as WCD Admin. Order 11-1987, eff. 1/1/88

Other Obligations of Insurers and the Department

436-120-190 (1) The insurer shall provide the information the Department needs under these rules about specific claims and about the insurer's vocational assistance program, including vocational assistance cost information, as prescribed by the Director.

(2) Upon written request by a worker, a worker's authorized representative or a worker's attending physician, that individual may review the vocational file of the insurer or the Department or be provided copies of vocational file information. If the "authorized representative" is other than the worker's attorney, that individual must have a written release signed by the worker. The insurer may review the Department's file.

(3) All disclosures by the Department of vocational information shall be made in accordance with the provisions of the Oregon Public Records Law, ORS 192.410 through 192.500; ORS 657.665 (Employment Division records); ORS 344.600 (Vocational Rehabilitation Division records); and, Title 42 United States Code, sections 290dd-3 and 290ee-3 (drug and alcohol abuse records).

(4) The department may charge a fee for each document, staff time, accounting fees and mailing costs, as prescribed by rules of the Director.

Hist: Filed 12/29/82 as WCD Admin. Order 11-1982, eff. 1/1/83 (Temporary)
Filed 6/30/83 as WCD Admin. Order 2-1983, eff. 6/30/83
Amended 12/14/83 as WCD Admin. Order 5-1983, eff. 1/1/84
Renumbered from OAR 436-61-177, 5/1/85
Amended 12/12/85 as WCD Admin. Order 7-1985, eff. 1/1/86
Amended 12/17/87 as WCD Admin. Order 11-1987, eff. 1/1/88

Authorization of Vocational Assistance Providers

436-120-200 (1) A vocational assistance provider must hold an authorization from the Director under this section. To become authorized the provider shall meet the requirements prescribed by the Director for its technical services, and its vocational assistance staff shall each hold certification by the Director under OAR 436-120-205. The provider also shall meet other applicable state and federal business requirements.

(2) The application of a vocational assistance provider for authorization shall be as prescribed by the Director, and shall include the provider's roster of certified staff and proposal for its technical services. The authorization will limit the provider to providing specified kinds of services, as determined by the Director's evaluation of the proposal for technical services and of the certifications of staff.

(3) Individuals seeking authorization as a vocational assistance provider shall be limited to three attempts to have an application for authorization approved by the Department. The Department shall not accept further applications until the applicants have completed one year of experience, subse-

quent to the third application, as a certified staff person with an authorized vocational assistance provider in Oregon.

(4) Vocational assistance providers authorized prior to January 1, 1988, wishing to continue providing vocational assistance under these rules, must submit new technical proposals, as prescribed by the Director, not later than December 31, 1988. The Director may consider the provider's previous plan conformance rate, or use additional criteria, when determining whether the provider's authorization may be continued.

Hist: Filed 12/4/81 as WCD Admin. Order 4-1981, eff. 1/1/82.
Amended 12/31/81 as WCD Admin. Order 8-1981, eff. 1/1/82 (Temporary)
Amended 5/26/82 as WCD Admin. Order 9-1982, eff. 6/1/82
Amended 6/30/83 as WCD Admin. Order 2-1983, eff. 6/30/83
Amended 12/14/83 as WCD Admin. Order 5-1983, eff. 1/1/84
Renumbered from OAR 436-61-180, 5/1/85
Amended 12/12/85 as WCD Admin. Order 7-1985, eff. 1/1/86
Amended 12/17/87 as WCD Admin. Order 11-1987, eff. 1/1/88

Standards for Authorized Providers; Sanctions

436-120-203 (1) Vocational assistance providers must comply with the following requirements in order to maintain their authorization under these rules:

(a) Maintain certified staff as indicated in its proposal for technical services;

(b) Maintain on file with Rehabilitation Review Section a correct current roster of certified staff;

(c) Meet applicable state or federal business requirements;

(d) Provide adequate training and supervision of certified staff;

(e) Provide each certified staff person with Department rules, bulletins or other information prescribed by the Director;

(f) Maintain such plan conformance rate as may be prescribed by the Director;

(g) Apply before the expiration date of the existing authorization for continuation of its authorization, as prescribed by the Director. Denial of continuation of an authorization will be considered a revocation.

(2) The Director is not obligated to look beyond the completed application and the Department's certification records to approve, deny or continue authorization. The Director may, subject to appeal under ORS 656.704(2), deny an application for authorization, reprimand the provider, place the provider on probation for a specified period, suspend or revoke the provider's authorization, levy fines or take any other action the Director deems appropriate if the Director finds:

(a) The provider has committed fraud or misrepresentation, or has made a serious error or omission, in connection with an application for authorization, a return-to-work plan or report, a billing, or the business activities or responsibilities of the provider or its staff under these or other rules of the Department; or

(b) The provider has failed to comply with the requirements in section (1) of this rule, or any other requirements of these rules.

Hist: Filed 12/17/87 as WCD Admin. Order 11-1987, eff. 1/1/88

Certification of Vocational Assistance Staff

436-120-205 (1) Vocational assistance staff, and individuals making determinations of workers' eligibility for vocational assistance, are required to hold certification from the Director under this rule.

(2) To be certified, an individual shall furnish an application, as prescribed by the Director, which demonstrates that the individual meets the requirements under section (3) of this rule. However, an individual certified prior to January 1, 1986, must reapply for certification under this rule no later than December 31, 1988. If such application is not made, the existing certification shall automatically expire on December 31, 1988.

(3) The types of certification, and qualification requirements, for an individual to become certified are described as follows:

(a) Full certification. This allows the individual to provide all eligibility evaluation and vocational assistance services except vocational testing and work evaluation. Full certification requires a master's degree in vocational rehabilitation; or, a master's degree in a field related to vocational rehabilitation, and one year of experience in performing vocational evaluations or developing individualized return-to-work plans; or, a bachelor's degree, and two years of such experience. All degrees must have been earned at an accredited institution. Regardless of these requirements, an individual will be considered qualified for full certification if accredited as a "Certified Rehabilitation Counselor (CRC)" by the Commission on Rehabilitation Counselor Certification; as a "Certified Insurance Rehabilitation Specialist (CIRS)" by the Certified Insurance Rehabilitation Specialist Commission; or, as a "Certified Vocational Evaluation Specialist (CVE)" or "Certified Work Adjustment Specialist(CWA)" by the Commission on Certification of Work Adjustment and Vocational Evaluation Specialists.

(b) Conditional certification. This allows the individual to provide, under the conditions specified in this subsection, all services allowed by full certification except for eligibility determination. This also allows the individual to provide, under the conditions specified in this subsection, the services allowed by certification for work evaluation. The following conditions apply to conditional certification:

(A) The individual shall work under the direct supervision of a designated staff individual who holds full certification or certification for work evaluation, respectively, and who cosigns

and assumes responsibility for all return-to-work plans, vocational and billing reports of the conditionally certified individual.

(B) The vocational assistance staff of the provider shall be comprised of at least one individual with full certification or certification for work evaluation for each individual with the respective conditional certification.

(C) With respect to full certification services, the individual shall have the same education as for full certification but may lack up to two years of the qualifying experience. The deficit in qualifying experience will be canceled at the rate of one month for each conforming return-to-work plan developed by the individual for return to work with a new employer and filed with the Rehabilitation Review Section, unless the Director prescribes otherwise. The Section will determine the number of plans which need to be submitted, 95% of which must be found in conformance with these rules, or the individual will be denied full certification and will automatically receive limited certification. Upon cancelation of the entire deficit within two years under the conditional certification, as verified to the Director by the individual's supervisor or supervisors, the individual will receive full certification. Otherwise, the conditional certification will expire at the end of two years.

(D) With respect to work evaluation services, the individual with a master's degree in counseling, psychology or a closely related discipline may lack up to one year of qualifying experience. An individual holding a bachelor's degree but lacking up to one year of qualifying experience administering recognized and standardized work sampling systems, may be granted conditional certification if the individual has one year of experience administering and interpreting vocational aptitude, dexterity and interest tests as well as experience using the Dictionary of Occupational Titles (DOT); or, has one year of a combination of experience using recognized and standardized work sampling systems and the testing and use of the DOT set forth above. All degrees must have been earned from an accredited institution. The remaining deficit in qualifying experience will be canceled at the rate of one month for each work evaluation and interpretive report completed by the individual and cosigned by a supervisor who is fully certified for work evaluation under subsection (3)(e). Upon cancelation of the entire deficit within one year under the conditional certification, as verified to the Director by the individual's supervisor, the individual will receive certification for work evaluation. Otherwise, the conditional certification will expire at the end of one year.

(c) Limited certification. This allows the individual to determine if the worker is eligible for vocational assistance, except where such determination requires a judgement as to whether the worker has a substantial handicap to suitable employment. Limited certification also allows the individual to provide the following direct employment services: Job search skills instruction, job development, return-to-work follow-up, labor market survey and job analysis. This certification requires a high school diploma or the equivalent, and one year of experience in processing workers' compensation claims, or in any one or more of job development, employe recruitment and selection in a wide range of occupations, job search skills instruction or a related field.

(d) Eligibility certification. This allows the individual to determine if the worker is eligible for vocational assistance based on information as to whether the worker can return to regular employment, other available and suitable employment with the employer at injury or customary work; or, whether the worker has a substantial handicap to employment. Eligibility certification requires a bachelor's degree from an accredited institution and two years experience reviewing medical and vocational information to determine the nature and extent of vocational assistance required to return the worker to suitable employment. This experience must have been gained within a workers' compensation or other similar insurance system.

(e) Certification for work evaluation. This certification requires a master's degree with an emphasis on work evaluation; or, a master's degree in counseling, psychology or a closely related discipline, and one year of experience using recognized and standardized work sampling systems; or, a bachelor's degree and two years of experience using recognized and standardized work sampling systems; or, a bachelor's degree and one year of experience using recognized and standardized work sampling systems, and one year of experience administering and interpreting vocational aptitude tests, dexterity tests, and interest tests, together with experience using the Dictionary of Occupational Titles.

(4) To do vocational testing but make no analysis of the test results in terms of implications for vocational assistance, an individual does not need certification under section (3) of this rule but shall hold authorization by the appropriate bodies other than the Department to administer the relevant tests. A vocational assistance provider which administers vocational test shall maintain documentation of this authorization.

(5) Equivalent experience, as determined by the Director, will be substituted for a required degree. The Director will make all evaluations of qualifications, including the determination whether particular experience is related to vocational assistance.

Hist: Filed 12/17/87 as WCD Admin. Order 11-1987, eff. 1/1/88

Standards for Certified Staff; Sanctions

436-120-207 (1) Certified individuals must comply with the following standards of conduct in order to maintain their certification:

(a) Certified individuals shall provide assistance in an objective manner, in accordance with these rules, in order to return the worker to suitable employment. Individuals shall not provide assistance if they have a material conflict of interest, or relevant and material prejudice concerning the worker.

(b) Certified individuals shall provide only vocationally relevant information regarding workers in written and oral reports.

(c) Certified individuals shall recommend workers only for employment which is suitable for the worker.

(d) Certified individuals shall not enter into any relationship with the worker to promote personal gain, or the gain of a person or organization in which the certified individual has an interest.

(e) Certified individuals shall not engage in the sexual harassment of workers. "Sexual harassment" means deliberate or repeated unsolicited comments, gestures or physical contact of a sexual nature.

(f) Certified individuals shall not make vocational assistance subject to any conditions other than those prescribed by these rules.

(g) Certified individuals shall fully inform the worker of the purpose of all testing and evaluations.

(2) The Director may, subject to appeal under ORS 656.704(2), take any one or more of the following actions against a certified individual or an applicant for certification: Denial of certification, reprimand, probation, suspension or revocation of certification, fines or such other action the Director deems appropriate. Such actions may be taken if the Director finds that the individual:

(a) Has failed to meet the certification requirements under OAR 436-120-205;

(b) Has failed to comply with the standards and prohibitions in section (1) of this rule;

(c) Has committed fraud or misrepresentation, or has made a serious error or omission, in connection with an application for certification, report or return-to-work plan, or the vocational assistance activities or responsibilities of a vocational assistance provider under these or other rules of the Department, or in connection with a comparable program in another jurisdiction;

(d) Has engaged in collusion to withhold information, or submit false or misleading information to an insurer, a vocational assistance provider or the Department;

(e) Has engaged in collusion to violate these rules or other rules of the Department, or any policies, guidelines or procedures issued by the Director; or

(f) Has failed to comply with generally accepted standards of conduct in the vocational rehabilitation profession.

Hist: Filed 12/17/87 as WCD Admin. Order 11-1987, eff. 1/1/88

Vocational Assistance Disputes, Administrative Reviews and Director's Orders

436-120-210 (1) Under ORS 656.283, a worker must first apply to the Director for administrative review of a vocational assistance matter before requesting a hearing on the matter. Such application must be made not later than the 60th day after the date the worker received notice of the insurer's action, when such notice is dated on or after January 1, 1988. An order of the Director under section (6) of this rule constitutes such a review.

(2) A worker who is dissatisfied with an action of the insurer in a vocational assistance matter should first attempt to resolve the matter with the insurer. The insurer shall promptly respond to the worker's request.

(3) A worker with unresolved dissatisfaction about a vocational assistance matter may request Rehabilitation Review Section to assist in resolving the matter. The section will promptly respond to the request.

(4) If Rehabilitation Review Section is not otherwise able to achieve resolution of a worker's dissatisfaction about a vocational assistance matter, the section may convene a conference of the parties. The section may require attendance by particular parties.

(5) A worker must provide information and participate in the administrative review as requested by the Rehabilitation Review Section. Failure to comply with with this section, without reasonable cause, will cause dismissal of the request. Once dismissed, under the provisions of this section, the worker may not subsequently request a review on the vocational assistance matter which prompted the initial request.

(6) If a worker's dissatisfaction about a vocational assistance matter has not been resolved by a conference or otherwise, the Director will issue a written decision within a reasonable time. This decision will be the final order of the Director in the matter, as prescribed in ORS 656.283. Appeal may be made as provided in that statute, but shall not stay compliance with the order.

(7) At any time, the Director may order the insurer to provide specified vocational assistance in order to achieve compliance with ORS chapter 656 and these rules. For pre-1986 injuries the order may provide that reimbursement, either partially or totally, will not be made for the costs of the specified vocational assistance or the previous vocational assistance, or both. The purpose of the reimbursement denial would be that the insurer not receive reimbursement for vocational assistance provided other than in accordance with ORS chapter 656 and these rules. Appeal may be made as provided in ORS chapter 656 but shall not stay compliance with the order.

Hist: Filed 12/14/83 as WCD Admin. Order 5-1983, eff. 1/1/84
Renumbered from OAR 436-61-191, 5/1/85
Amended 12/12/85 as WCD Admin. Order 7-1985, eff. 1/1/86
Amended 12/17/87 as WCD Admin. Order 11-1987, eff. 1/1/88

Fee Schedule and Conditions for Payment of Vocational Assistance Costs

436-120-215 (1) Insurers shall pay vocational assistance providers according to this rule for vocational services to

workers found eligible on or after January 1, 1988. This rule also applies to services provided to workers determined eligible prior to and receiving services on January 1, 1988, when the type of service changes from evaluation to plan development, or from one type of plan to another; and, to all workers receiving vocational assistance no later than April 1, 1988.

(2) The maximum amounts the insurer may spend per service each time the service is provided, except where the insurer determines that the case warrants exceeding the limit, are described in this section. All activities normally associated with each category of service are included in the fee ceiling except those which are separately identified in the schedule.

(a) Eligibility evaluation.

(A) To determine whether the worker can return to the job at injury, other suitable jobs with the employer, other customary employment, and whether the worker has a substantial handicap to employment: $500

(B) To perform the determination in paragraph (A), except whether the worker has a substantial handicap to employment: $300

(b) Vocational evaluation. To determine the nature and extent of vocational assistance the worker needs to return to suitable new employment. If done immediately after an eligibility evaluation, any unused balance from the eligibility evaluation may be used in addition to the amount provided for vocational evaluation: $200

(c) Vocational testing and work evaluation. Payment shall be at the usual and customary rates for the service.

(d) Computer-generated assessments. Entering data and analyzing the results: $100

(e) On-the-job evaluation. Arranging the job experience, and observing and evaluating the worker's performance in the job setting: $800

(f) Job analysis. Requires an on-site visit: $100

(g) Job search skills:

(A) Individual instruction, per worker: $300

(B) Group instruction, including any activities related to preparation for the class. The total charges for the group session shall be prorated over the number of workers in the group, according to the following schedule:

(i) 2 workers: $525

(ii) 3 workers: $555

(iii) 4 workers: $585

(iv) 5 workers: $615

(v) 6 workers: $645

(vi) 7 workers: $675

(vii) 8 workers: $705

(viii) 9 workers: $735

(ix) 10 more workers: $825

(h) Labor market survey. Collecting and compiling labor market information for an occupation: $200

(i) Direct employment plan development: $800

(j) Training plan development. Including the arrangement of training sites: $1500

(k) Training progress monitoring. The amount paid for the duration of the training must not exceed the number of months of training multiplied by the following average monthly fee: $150

(l) Job development, per month: $350

(m) Return-to-work bonus. Paid only if the worker has returned to suitable employment for 60 days. This bonus shall be a percentage of the worker's gross monthly return-to-work wage, according to the following schedule:

(A) RTW within three months of date of assignment: 50%

(B) RTW within two months of training completion date: 40%

(C) RTW, difficult case: 60%

(D) RTW, all other: 30%

(n) Return-to-work follow-up, per month: $150

(o) Workers' Reemployment Reserve assistance negotiation. Contacts with the worker, employer, physician, and vendors to arrange worksite modification, wage subsidy or obtained employment purchases under OAR 436-110, according to the following schedule:

(A) Worksite modification: $750

(B) Wage subsidy: $150

(p) Travel/wait, meals and lodging and mileage.

(A) Travel/wait time charges shall not exceed $25 per hour. Wait time shall not be paid for any period longer than one-half hour.

(B) Meals, lodging and mileage shall be paid at the rates under OAR 436-120-220(4).

(p) Dispute resolution participation. For file review and attendance at conferences convened by the Rehabilitation Review Section, when such participation is required by the insurer or the Section: $150

(3) The maximum amounts the insurer may spend for each eligible worker, except where the insurer determines that the the case warrants exceeding the limit, are as follows:

(a) Training.

(A) Professional services: $7,500

(B) Total direct worker purchases: $9,000

(C) Tuition and training fees, under paragraph (B): $4,500

(b) Non-training.

(A) Professional services: $3,000

(B) Direct worker purchases: $1,500

(4) If the Rehabilitation Review Section finds that a return-to-work plan does not conform to these rules because the plan is not likely to result in suitable employment, and the insurer implements the plan after being notified of nonconformance by the Section, the insurer shall not charge the costs of the plan to the insured employer by means of assessment, increased premium, change in classification or experience rating, or by any other means unless the employer agrees with the plan.

Hist: Filed 12/17/87 as WCD Admin. Order 11-1987, eff. 1/1/88

Reimbursement of Vocational Assistance Costs for Pre-1986 Injuries

436-120-220 (1) This rule applies only to pre-1986 injuries, and carries out the provisions of section 15, chapter 600, Oregon Laws 1985.

(2) The Department will reimburse insurers for costs of vocational assistance with respect to pre-1986 injuries only. Reimbursement is subject to the availability of funds.

(3) The following kinds of reimbursements are the only kinds allowable under these rules:

(a) Reimbursement of costs of direct worker purchases under OAR 436-120-087, including necessary costs of repossession.

(b) Reimbursement of charges for vocational assistance services of vocational assistance providers under selections made in accordance with OAR 436-120-070, and reimbursement of costs of vocational assistance services provided by certified staff of insurers which are authorized vocational assistance providers. This subsection does not refer to charges or costs relating to determination of a worker's eligibility for vocational assistance, except for that portion of such determination requiring an evaluation to determine under OAR 436-120-035 whether the worker has a substantial handicap to employment.

(c) Reimbursement for temporary disability compensation as provided in OAR 436-120-250.

(d) Reimbursement for wage subsidy payments under on-the-job training contracts as described in OAR 436-120-075(3)(a).

(4) The following procedures and conditions apply to reimbursement for costs of vocational assistance:

(a) Reimbursement shall only be claimed and made for vocational assistance provided in accordance with ORS chapter 656 and these rules.

(b) Reimbursement will only be made if the vocational assistance provider was appropriately authorized under OAR 436-120-200, and the providing staff had the appropriate certifications under OAR 436-120-205.

(c) Reimbursement will only be made if the insurer had authorized the vocational assistance and, before the reimbursement, obtained any required administrative approvals. Reimbursement of costs for vocational assistance provided under a waiver pursuant to OAR 436-120-003 shall only be made if the waiver was granted prior to providing the assistance.

(d) Reimbursement will only be made if the insurer's request for reimbursement is accompanied by the supporting billing reports of the vocational assistance provider and, unless otherwise prescribed by the Director, the supporting vocational progress reports. These reports shall be in the form prescribed by the Director, shall provide information on the worker's vocational progress since the previous report, and shall document the kinds of services, amounts of time spent, costs paid for direct worker purchases, and charges of the provider, as well as other relevant information prescribed by the Director. Requests for reimbursement shall be made in the manner prescribed by the Director. Reimbursement to any particular insurer will be no less often than once in each calendar quarter. This subsection does not apply to reimbursement under OAR 436-120-250 of temporary disability compensation.

(e) Reimbursement for costs exceeding the fee schedule under OAR 436-120-215, or the control figures established by the Director shall be made only with administrative approval. The Director shall establish control figures for vocational assistance staff services, including travel, and for the total of direct worker purchases. In both cases, the control figures shall be separate for vocational assistance involving training and not involving training. These control figures will be set at levels sufficiently high, in the judgment of the Director, to cover at least 90 percent of the cases, according to expenditure data available to the Department or estimated where necessary. An administrative approval under this subsection will be based on

whether the costs exceeding the control figure were necessary and not unreasonably high under the circumstances. This subsection does not apply to reimbursement under OAR 436-120-250 of temporary disability compensation.

(f) The maximum reimbursable hourly rate under this rule for professional service hours of vocational assistance staff is $50 per hour. This hourly rate is superseded by the fee schedule under OAR 436-120-215, at the times set forth in section (1) of that rule. The maximum reimbursable rate under this rule for travel time and waiting time shall not exceed $25 per hour.

(g) The Department will reimburse for travel expenses for transportation, meals and lodging of vocational assistance staff in connection with providing vocational assistance. The conditions and rates for reimbursement are as follows:

(A) Transportation. Private car mileage will be reimbursed at $.21 per mile. Costs incidental to the private car mileage, such as parking fees, will also be reimbursed. Travel by commercial carrier will be reimbursed if justified by lower overall cost.

(B) Meals and lodging. Expenses for non-overnight travel will not be reimbursed. For overnight travel, meal and lodging expense will be reimbursed under a 24-hour allowance system. The total allowance, with receipts for commercial lodging, is $46 for a 24-hour period of travel, increased or decreased by $1 for each hour of travel more or less than the 24-hour period. The adjustment will be based on the number of hours after rounding to the nearest whole number. For travel without commercial lodging receipts the allowance is $33, with the other conditions remaining the same.

(h) OAR 436-120-250, in addition to this rule, applies to reimbursement for temporary disability compensation.

(i) The insurer shall request reimbursement only of those costs which the insurer has paid. Reimbursed costs shall not be charged by the insurer to the insured employer as claim costs or by any other means. Reimbursements requested by the insurer before the insurer has paid the respective costs are subject to denial or recovery by the Department, in addition to any penalties under ORS chapter 656 and these rules. The insurer's payment check issued within reasonable time for the insurer's internal processing after the payment authorization will be considered payment as of the time of the authorization.

(5) Further procedures and conditions relating to reimbursement for direct worker purchases are as follows:

(a) If the cost for a single item is over $1,000, three competitive quotes shall be obtained. If three quotes are not available, documentation of the efforts to obtain three quotes shall be made (i.e., sole source). The lowest quote shall normally be selected.

(b) The insurer shall not issue multiple orders to circumvent the requirements of this section.

(6) The insurer shall retain right and title to the nonexpendable property paid for under this rule for the period of time that the insurer considers necessary to determine the success of the vocational assistance, normally 60 days of continuous employment. At the end of that period the insurer shall either assign the right and title to the worker if the worker is working in the occupation for which the property was provided, or repossess the property. The following procedures and conditions apply with respect to nonexpendable property paid for under this rule:

(a) Property repossessed by the insurer shall, if feasible, be reassigned to another worker eligible for the property; or, the property may be transferred to another insurer for such reassignment. Each insurer shall maintain documentation of such transfers for audit purposes, including the estimated value of the property. Unless so reassigned, the property shall be sold within six months and the proceeds transmitted promptly to the Department. If property to which title is held by the insurer suffers an insured loss, the insurance proceeds shall be transmitted promptly to the Department.

(b) If the worker fails to meet the conditions prescribed by the insurer for the care and protection of property in the worker's custody, and the property suffers damage or loss, the insurer shall not replace it.

(7) The insurer and each vocational assistance provider shall maintain case files, records, reports, receipts and canceled checks documenting vocational assistance costs for which reimbursement has been requested. These records shall be maintained in accordance with OAR 436-50 or for a period of three years after the last reimbursement request.

(8) Under ORS 656.593, if the worker or the worker's beneficiaries recover damages from the employer or a third person, the proceeds are subject to lien by the department and recovery of its share of any reimbursements made to the insurer under these rules.

Hist: Filed 5/22/80 as WCD Admin. Order 6-1980, eff. 6/1/80
Amended 12/4/81 as WCD Admin. Order 4-1981, eff. 1/1/82
Amended 12/29/82 as WCD Admin. Order 11-1982, eff. 1/1/83 (Temporary)
Amended 6/30/83 as WCD Admin. Order 2-1983, eff. 6/30/83
Amended 12/14/83 as WCD Admin. Order 5-1983, eff. 1/1/84
Renumbered from OAR 436-61-300, 5/1/85
Amended 12/12/85 as WCD Admin. Order 7-1985, eff. 1/1/86
Amended 12/17/87 as WCD Admin. Order 11-1987, eff. 1/1/87

Temporary Disability Compensation During Training

436-120-230 (1) OAR 436-60, in addition to this rule, applies to payment of awards for permanent disability and payment of temporary disability compensation.

(2) Workers injured after December 31, 1973, are entitled to temporary disability compensation from the insurer while enrolled and actively engaged in training under these rules. Upon completion, termination or interruption of the training, any award payment shall be resumed. If no award payment remains due, temporary disability compensation shall continue

pending a subsequent determination under ORS 656.268 unless the worker has returned to regular employment.

(3) If, for a worker injured after December 31, 1973, the insurer provides training after the issuance of a Determination Order, Opinion and Order of a Referee, Order on Review, or decision of the Court of Appeals, the insurer shall suspend any award payments due under the order and pay temporary disability compensation in accordance with section (2) of this rule. During periods when temporary disability compensation is not due in accordance with section (2) of this rule, the insurer shall resume any suspended award payments. Upon completion or ending of the training, unless the worker then is not medically stationary, the insurer shall stop temporary disability compensation payments and resume any suspended award payments.

(4) Temporary disability compensation paid to a medically stationary worker while the worker was not enrolled and actively engaged in training may be recovered through the procedure under ORS 656.268(4).

Hist: Filed 12/20/73 as WCD Admin. Order 6-1973, eff. 1/11/74
Amended 11/5/74 as WCD Admin. Order 45-1974, eff. 11/5/74 (Temporary)
Amended 2/5/75 as WCD Admin. Order 4-1975, eff. 2/26/75
Amended 3/29/77 as WCD Admin. Order 3-1976, eff. 4/1/76
Amended 9/29/77 as WCD Admin. Order 3-1977, eff. 10/4/77 (Temporary)
Amended 2/1/78 as WCD Admin. Order 1-1978, eff. 2/1/78
Amended 5/22/80 as WCD Admin. Order 6-1980, eff. 6/1/80
Amended 12/4/81 as WCD Admin. Order 4-1981, eff. 1/1/82
Amended 6/30/83 as WCD Admin. Order 2-1983, eff. 6/30/83
Amended 12/14/83 as WCD Admin. Order 5-1983, eff. 1/1/84
Renumbered from OAR 436-61-410, 5/1/85
Amended 12/12/85 as WCD Admin. Order 7-1985, eff. 1/1/86
Amended 12/17/87 as WCD Admin. Order 11-1987, eff. 1/1/88

Reimbursement of Temporary Disability Compensation Costs for Pre-1986 Injuries

436-120-250 (1) This rule applies only to pre-1986 injuries, and carries out the provisions of section 15, chapter 600, Oregon Laws 1985.

(2) Subject to all of the conditions of these rules, the Department will reimburse an insurer for the net amount of sums paid in accordance with these rules as temporary disability compensation to a worker during the time enrolled and actively engaged in training after the date the worker became medically stationary.

(3) The insurer shall make application to the Department at the end of each calendar quarter for reimbursement under this rule. The Department will approve the application and reimburse funds after deducting amounts owed the Department, if:

(a) The insurer started vocational assistance in a timely manner; and

(b) The net amount of compensation paid is verifiable upon audit by the Department.

(4) An insurer which has made a timely effort to recover overpayments as provided in OAR 436-120-230(4) may be reimbursed for unrecovered overpayments unless they resulted from the insurer's failure to monitor the training status of the worker. If the insurer recovers an overpayment after reimbursement, the insurer shall repay the Department to the extent of the recovery.

(5) Whenever reimbursement is denied, the insurer shall not charge the costs of temporary disability compensation to the insured employer by means of assessment, increased premium or change in classification or experience rating, or by any other means.

(6) An insurer aggrieved by a decision of the Department under this rule may request a hearing in accordance with ORS 656.704(2), ORS chapter 183 and this rule. The request for hearing must be made within 30 calendar days of the date of the decision. The decision of the Department becomes a final order if not appealed within 30 calendar days. Upon receipt of a request for hearing, the Director will within 30 days affirm or change the decision. If the issues are not resolved by the Director within 30 days, the Director will submit the appeal to Hearings Division for a hearing.

(7) The conduct of hearings arising under this rule, and the judicial review by the Court of Appeals, will be as provided in ORS 183.415 through 183.495, except that:

(a) The Board may promulgate rules for the conduct of these hearings;

(b) The Order of the Referee, under the rules of the Board, will be considered the final order of the Director; and

(c) The Director will have the same right to judicial review of the Order of the Referee as any other person who is adversely affected or aggrieved by the order.

Hist: Filed 12/20/73 as WCD Admin. Order 6-1973, eff. 1/11/74
Amended 11/5/74 as WCD Admin. Order 45-1974, eff. 11/5/74 (Temporary)
Amended 2/6/75 as WCD Admin. Order 4-1975, eff. 2/26/75
Amended 3/29/76 as WCD Admin. Order 1-1976, eff. 4/1/76
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Amended 2/1/78 as WCD Admin. Order 1-1978, eff. 2/1/78
Amended 5/22/80 as WCD Admin. Order 6-1980, eff. 6/1/80
Amended 12/4/81 as WCD Admin. Order 4-1981, eff. 1/1/82
Amended 6/30/83 as WCD Admin. Order 2-1983, eff. 6/30/83
Amended 12/14/83 as WCD Admin. Order 5-1983, eff. 1/1/84
Renumbered from OAR 436-61-430, 5/1/85
Amended 12/12/85 as WCD Admin. Order 7-1985, eff. 1/1/86
Amended 12/17/87 as WCD Admin. Order 11-1987, eff. 1/1/88

Audits

436-120-255 Insurers, vocational rehabilitation organizations and other contractors with vocational assistance providers under these rules are subject to periodic program and fiscal audits by the Department. All reimbursements are subject to subsequent audits, and may be disallowed on any of the grounds set forth in these rules. Disallowed reimbursements may be recovered by the Department directly or from future reimbursements. If the Department finds upon audit that procedures which led to disallowed reimbursements are still being

used, the Department may withhold further reimbursements until corrections satisfactory to the Department are made.

Hist: Filed 12/12/85 as WCD Admin. Order 7-1985, eff. 1/1/86.

Hearings and Litigation on Vocational Assistance

436-120-260 (1) ORS 656.283 and OAR 436-120-210 prescribe conditions for a hearing on a vocational assistance matter.

(2) Insurers are responsible for defending issues involving reimbursement of vocational assistance costs by the Department whenever vocational assistance is an issue for hearing or litigation, unless the Director for good cause agrees otherwise. Insurers are also responsible for paying, without reimbursement, the costs connected with preparing for and defending such issues. The Director may deny reimbursement of vocational assistance costs for failure to comply with this section.

(3) Upon request by any party, the Department will provide a copy of relevant vocational assistance documents for use in a hearing.

(4) The Department will permit any of its employes to testify in a hearing on vocational assistance issues upon request by any party, without the need for subpoena or witness fee. However, the party shall be responsible for notification to the Department sufficiently timely to permit the employe's attendance.

Hist: Filed 5/26/82 as WCD Admin. Order 9-1982, eff. 6/1/82
Amended 6/30/83 as WCD Admin. Order 2-1983, eff. 6/30/83
Amended 12/14/83 as WCD Admin. Order 5-1983, eff. 1/1/84
Renumbered from OAR 436-61-970, 5-1-85
Amended 12/12/85 as WCD Admin. Order 7-1985, eff. 1/1/86

Civil Penalties; Other Sanctions

436-120-270 (1) An insurer failing to comply with these rules may be assessed a civil penalty of not more than $2,000 for each violation, or $10,000 in the aggregate for all violations within any three-month period. Each violation, or each day a violation continues, shall be considered a separate violation. These penalties shall be assessed in accordance with ORS 656.745.

(2) Under ORS 656.447 the Insurance Commissioner may suspend or revoke the authorization of a guaranty contract insurer which has failed to comply with orders of the Director, the provisions of ORS chapter 656 or any rule promulgated pursuant to that chapter.

Hist: Filed 12/4/81 as WCD Admin. Order 4-1981, eff. 1/1/82
Amended 6/30/83 as WCD Admin. Order 2-1983, eff. 6/30/83
Amended 12/14/83 as WCD Admin. Order 5-1983, eff. 1/1/84
Renumbered from OAR 436-61-981, 5/1/85
Amended 12/12/85 as WCD Admin. Order 7-1985, eff. 1/1/86
Amended 12/17/87 as WCD Admin. Order 11-1987, eff. 1/1/88

EXHIBIT "B" (for WCD Admin. Order 11-1987)

BEFORE THE DIRECTOR OF THE DEPARTMENT OF INSURANCE AND FINANCE OF THE STATE OF OREGON

In the Matter of the Amendment of OAR Chapter 436, Workers' Compensation Division, Division 120, Vocational Assistance to Injured Workers	)))))	STATUTORY AUTHORITY, STATEMENT OF NEED, PRINCIPAL DOCUMENTS RELIED UPON AND STATEMENT OF FISCAL IMPACT

1. Citation of Statutory Authority: The statutory authority for promulgation of these rules is ORS 656.726(3) which authorizes the Director to make all rules reasonably required to administer, regulate and enforce ORS chapter 656; ORS 656.340(9) which requires the Director to adopt rules governing the provision of vocational assistance to injured workers; and, ORS 656.283(2) which requires workers who are dissatisfied with an insurer's action regarding a vocational assistance matter to apply to the Director for administrative review before requesting a hearing on the matter.

2. Need for Amendment: The need for this amendment is to give vocational assistance to injured workers and to implement changes contained in House Bill 2900 enacted by the 1987 Legislative Session (chapter 884, Oregon Laws 1987.

3. Principal Documents Relied Upon: ORS chapter 656.

4. Fiscal and Economic Impact: Workers, employers generally, insurers authorized to transact workers' compensation insurance in Oregon, self-insured employers and private vocational assistance organizations will be economically affected.

Dated this 1st day of December, 1987.

Department of Insurance and Finance

Theodore R. Kulongoski, Director

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IN THE COURT OF APPEALS OF THE
STATE OF OREGON

In the Matter of the Compensation of
Mark L. Queener, Claimant.

QUEENER,
Petitioner,

v.

SAIF CORPORATION et al,
Respondents.

(WCB 85-08542, WCB 85-10120,
WCB 85-10639 & WCB 85-13873;
CA A41210)

Judicial Review from Workers' Compensation Board.

Argued and submitted April 20, 1987.

James L. Edmunson, Eugene, argued the cause for petitioner. With him on the brief was Malagon & Moore, Eugene.

Darrell E. Bewley, Assistant Attorney General, Salem, argued the cause for respondent SAIF Corporation/ Bohemia Inc. With him on the brief were Dave Frohnmayer, Attorney General, and Virginia L. Linder, Solicitor General, Salem.

Richard W. Butler, Eugene, waived appearance for respondent Liberty Northwest/Bohemia, Inc.

George W. Goodman, McMinnville, waived appearance for respondent Liberty Northwest/Ty Logging.

Ridgway K. Foley, Jr., P.C., Portland, waived appearance for respondent Liberty Northwest/Nelson & Nelson.

Before Richardson, Presiding Judge, and Newman and Deits, Judges.

PER CURIAM

Affirmed.

PER CURIAM

The sole issue presented by this workers' compensation case is whether claimant is entitled to insurer paid attorney fees for his efforts in obtaining a hearing pursuant to ORS 656.307 to determine the responsible insurer for his work related injury. Although claimant's attorney may be entitled to compensation, we agree with the Workers' Compensation Board that the attorney fees are not the responsibility of the carrier.

Claimant argues that SAIF had unreasonably delayed payment of compensation, because it denied responsibility and suggested that claimant file against another employer. In support of his argument, he cites OAR 436-60-180, which requires that insurers expedite claim processing by "immediate priority investigation to determine responsibility and whether the claim is otherwise a compensable injury." We do

not agree that the duty created by this rule goes so far as to require that insurers initiate a proceeding under ORS 656.307 or investigate alternative claims against other parties when the claimant has not filed claims against those parties. Under the circumstances, SAIF did not act unreasonably and should not be required to pay claimant's attorney fees.

Affirmed.

IN THE COURT OF APPEALS OF THE STATE OF OREGON

In the Matter of the Compensation of Merlyn G. Johnsen, Claimant.

JOHNSEN,
Petitioner,

v.

HAMILTON ELECTRIC et al,
Respondents.

(WCB 83-06970; CA A42318)

Judicial Review from Workers' Compensation Board.

Argued and submitted November 2, 1987.

David C. Force, Eugene, argued the cause and submitted the brief for petitioner.

Brad Scheminske, Portland, argued the cause for respondents Argonaut Insurance Co. and Hamilton Electric. With him on the brief were Richard W. Davis, Bostwick & Lyons, Portland.

Darrell E. Bewley, Assistant Attorney General, Salem, argued the cause for respondent SAIF Corporation. With him on the brief were Dave Frohnmayer, Attorney General, and Virginia L. Linder, Solicitor General, Salem.

Before Buttler, Presiding Judge, and Warren and Rossman, Judges.

PER CURIAM

Petition dismissed.

PER CURIAM

In this worker's compensation case, claimant seeks a determination that he suffers from a compensable asbestos-related lung condition and that annual diagnostic chest x-rays are compensable. We dismiss the petition because the record indicates that all the parties were not served with a copy of the petition for judicial review as required by ORS 656.298(3). *Zurich Ins. Co. v. Diversified Risk Management*, 300 Or 47, 706 P2d 178 (1985).

Petition dismissed.

IN THE COURT OF APPEALS OF THE
STATE OF OREGON

In the Matter of the Compensation of
William S. Nolan, Claimant.
WEYERHAEUSER COMPANY,
Petitioner,
v.
NOLAN,
Respondent.
(WCB 85-12463; CA A41393)

Judicial Review from Workers' Compensation Board.

Argued and submitted June 8, 1987.

Paul L. Roess, Coos Bay, argued the cause for petitioner. With him on the brief was Foss, Whitty & Roess, Coos Bay.

Robert K. Udziela, Portland, argued the cause for respondent. With him on the brief were Daniel C. Dziuba, and Pozzi, Wilson, Atchison, O'Leary & Conboy, Portland.

Before Warden, Presiding Judge, and Joseph, Chief Judge, and Van Hoomissen, Judge.

JOSEPH, C. J.

Affirmed.

JOSEPH, C. J.

Employer seeks review of an order of the Workers' Compensation Board which held that employer could not unilaterally deny a claim and refuse to pay compensation awarded by a determination order. We affirm.

Claimant suffered a low back injury in February, 1979. His claim was first closed by a determination order in November, 1980. It was reopened as an aggravation claim in October, 1983, and closed again on August 27, 1985, by a determination order which awarded benefits for temporary total disability from October 7, 1983, to September 25, 1984, and 20 percent unscheduled permanent partial disability. After employer's request for reconsideration, another determination order issued on September 13, 1985, affirming the August 27, 1985, order "in all respects." On October 7, 1985, employer issued a denial of temporary disability benefits for the period March 24, 1984, through September 25, 1984, because it believed that claimant was "medically stationary"[1] during that time.

Claimant challenged that denial and sought penalties and attorney fees for an unreasonable refusal to pay compensation in compliance with the orders of August 27 and September 13, 1985. The referee affirmed those orders, awarded

[1] ORS 656.005(17) defines "medically stationary" to mean that "no further material improvement would reasonably be expected from medical treatment, or the passage of time."

claimant a total of $1,050 in attorney fees and imposed a penalty of 15 percent of the total temporary disability benefits due under the orders. In determining the penalty, she considered the evidence that claimant was medically stationary as of March 24, 1984, as a mitigating factor.[2] The Board affirmed the referee.

Employer argues that it should not have been required to pay temporary disability benefits for the March to September, 1984, period when claimant was medically stationary, because the order for payment was clearly in error. Employer also claims that no statute requires that an award by the Evaluation Division by determination order be paid

pending appeal. We have held that an employer may not unilaterally terminate an award of benefits made in a determination order and must pay the benefits pending the hearing and review. In *Georgia Pacific v. Piwowar*, 86 Or App 82, 85, 738 P2d 225, *rev allowed* 304 Or 240 (1987), the employer argued that its duty to pay benefits ended when it denied the claim, pursuant to the last clause in ORS 656.262(2): " 'except when the right to compensation is denied * * *.' " In interpreting the quoted portion of the statute, we said:

> "[I]t 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 terminate benefits." (Emphasis in original.)

The same rationale is applicable in this case. After affirmance of the August 27, 1985, determination order, employer could have requested a hearing pursuant to ORS 656.319. Instead, it issued a denial. An employer may not circumvent the claims processing procedure simply by issuing a denial; it must follow the procedures in the Workers' Compensation Law. *Georgia Pacific v. Piwowar, supra*, 86 Or App at 85. The referee properly found employer's unilateral termination of benefits unreasonable and assessed a penalty.

Employer also argues that an excessive award of temporary total disability benefits might result in claimant's receiving a windfall, because the offset allowed by the statute might not permit a full recovery by employer if claimant's permanent partial disability benefits are not enough. Although that is a possibility, it is a necessary consequence of a procedure designed to insure prompt claim processing. *See Georgia Pacific v. Piwowar, supra*, 86 Or App at 85. If temporary total disability benefits previously paid exceed the award of permanent partial disability to be paid, the overpayment must be absorbed by employer. *See Boise Cascade Corp. v. Jones*, 63 Or App 194, 663 P2d 427 (1983).

Affirmed.

[2] The referee could have imposed a penalty of 25 percent. ORS 656.262(10).

IN THE COURT OF APPEALS OF THE
STATE OF OREGON

In the Matter of the Compensation of
Leonila C. Utrera, Claimant.

UTRERA,
Petitioner,

v.

DEPT. OF GENERAL SERVICES et al,
Respondents.

(WCB 85-14220; CA A42877)

Judicial Review from Workers' Compensation Board.

Argued and submitted November 2, 1987.

James L. Edmunson, Eugene, argued the cause for petitioner. With him on the brief were Karen M. Werner and Malagon & Moore, Eugene.

Darrell E. Bewley, Assistant Attorney General, Salem, argued the cause for respondents. With him on the brief were Dave Frohnmayer, Attorney General, and Virginia L. Linder, Solicitor General, Salem.

Before Buttler, Presiding Judge, and Warren and Rossman, Judges.

BUTTLER, P. J.

Reversed and remanded.

BUTTLER, P. J.

Claimant seeks review of an order of the Workers' Compensation Board affirming the referee's determination that her claim was not prematurely closed and that she is not entitled to additional permanent partial disability.

At the time of claim closure, November 8, 1985, all medical reports indicated that claimant was medically stationary from a physical standpoint. By that time, however, at least two doctors had diagnosed significant depression, and she had been referred for pain therapy. Not until six months later did Dr. Friedman, a psychologist, expressly state that claimant's psychological condition was related to her compensable injury and that she was not psychologically stationary. His opinion does not state that she was not psychologically stationary at the time of claim closure; however, that conclusion is implicit, because Friedman was treating her for the same depressive condition that had been identified before the claim was closed, and it had only improved since that time.

A claimant's psychological condition should be considered in determining whether the claim should be closed. *Rogers v. Tri-Met,* 75 Or App 470, 706 P2d 209 (1985). Although Friedman's report was not available at the time of closure, it was available at the time of the hearing, and the referee and the Board should have considered it in determining whether claimant's condition was psychologically station-

ary at the time of closure. *Scheuning v. J. R. Simplot & Company,* 84 Or App 622, 735 P2d 1, *rev den* 303 Or 590 (1987).

Reversed and remanded.

IN THE COURT OF APPEALS OF THE STATE OF OREGON

In the Matter of the Compensation of Henry L. Mischel, Claimant.

MISCHEL,
Petitioner - Cross-Respondent,

v.

PORTLAND GENERAL ELECTRIC COMPANY,
Respondent - Cross-Petitioner.

In the Matter of the Compensation of Henry L. Mischel, Claimant.

PORTLAND GENERAL ELECTRIC COMPANY,
Petitioner,

v.

MISCHEL,
Respondent.

(WCB 82-10262; 84-00903;
CA A41734 (Control); CA A41856)
(Cases Consolidated)

Judicial Review from Workers' Compensation Board.

Argued and submitted October 12, 1987.

Karen M. Werner, Eugene, argued the cause for petitioner - cross-respondent and respondent. With her on the briefs were James L. Edmunson and Malagon & Moore, Eugene.

Craig A. Crispin, Portland, argued the cause for respondent - cross-petitioner and petitioner. With him on the brief was Bullard, Korshoj, Smith & Jernstedt, P.C., Portland.

Before Buttler, Presiding Judge, and Warren and Rossman, Judges.

WARREN, J.

Affirmed on petition and cross-petition in CA A41734 and on petition in CA A41856.

WARREN, J.

Claimant seeks review of an order of the Workers' Compensation Board reversing the referee's determination that his heart attack is compensable. Employer cross-petitions for review of the Board's determination that claimant is entitled to attorney fees pursuant to ORS 656.262(10) and ORS 656.382 for employer's late denial of the claim in A41734.

Employer in a consolidated case also seeks review of a separate Board order requiring it to pay temporary total disability ordered in A41734 in addition to disability paid to claimant under a collective bargaining agreement in A41856. We affirm the finding that claimant's heart attack is not compensable and write only to address the issues raised by employer's cross-petition in A41734 and its petition in A41856.

The Board determined that, although the heart attack is not compensable, employer had acted unreasonably in denying the claim more than 60 days after it had received notice. At the time when the claim was filed, over one year after the heart attack, claimant was working, so he was not entitled to interim compensation. The Board did not assess a penalty, because it determined that there were no amounts then due, but it awarded claimant attorney fees for employer's late denial, citing *Spivey v. SAIF*, 79 Or App 568, 720 P2d 755 (1986). In *Spivey* we held that attorney fees could be assessed against an employer under ORS 656.262(10) for an unreasonable denial, whether or not there were amounts then due and owing. We take this opportunity to explain that holding.

ORS 656.262(10) provides:

> "If the insurer or self-insured employer unreasonably delays or unreasonably refuses to pay compensation, or unreasonably delays acceptance or denial of a claim, the insurer or self-insured employer shall be liable for an additional amount up to 25 percent of the amounts then due plus any attorney fees which may be assessed under ORS 656.382."

If there is an unreasonable delay in denying a claim, the claimant is entitled to a penalty on the amount then due *plus* attorney fees "which may be assessed under ORS 656.382." The right to attorney fees under ORS 656.262(10) is not contingent on there being an amount "then due" on which to assess a penalty. The attorney fee is payable by virtue of the unreasonable delay alone.

ORS 656.382 provides, in part:

> "(1) If an insurer or self-insured employer refuses to pay compensation due under an order of a referee, board or court, or otherwise unreasonably resists the payment of compensation, the employer or insurer shall pay to the claimant or the attorney of the claimant a reasonable attorney fee as provided in subsection (2) of this section. To the extent an employer has caused the insurer to be charged such fees, such employer may be charged with those fees.
>
> "(2) If a request for hearing, request for review, appeal or cross-appeal to the Court of Appeals or petition for review to the Supreme Court is initiated by an employer or insurer, and the referee, board or court finds that the compensation awarded to a claimant should not be disallowed or reduced, *the employer or insurer shall be required to pay to the claimant or the attorney of the claimant a reasonable attorney fee in an amount set by the referee, board or the court for legal representation by an attorney for the claimant at and prior to the hearing, review on appeal or cross-appeal.*" (Emphasis supplied.)

Under that section, a "reasonable attorney fee * * * for legal representation * * * at and prior to the hearing, review on

appeal or cross-appeal" may be assessed when the employer unreasonably resists payment of compensation or refuses to pay compensation ordered to be paid by a referee, ORS 656.382(1), and when the claimant prevails on an employer's petition. ORS 656.382(2). We do not read ORS 656.262(10) to say that attorney fees can be allowed under that statute only under the circumstances described in ORS 656.382. We understand it to provide that attorney fees that may be assessed under the circumstances described in ORS 656.382 may also be assessed for an unreasonable denial. ORS 656.382 does not impose additional restrictions on when attorney fees may be assessed under ORS 656.262(10). The Board could properly assess attorney fees pursuant to ORS 656.262(10) and ORS 656.382, even though no compensation was then due.

When claimant became disabled by the heart attack, employer began paying benefits pursuant to a collective bargaining agreement which provides for 80 percent of wages for a work-related injury or 100 percent of wages for a nonwork-related illness or injury. Consistent with its position that the heart attack was not work-related, employer paid claimant

100 percent of his wages. When the referee determined that the claim was compensable, it ordered employer to pay temporary total disability benefits for the period of claimant's total disability, as well as penalties and interest. Employer had already paid claimant benefits under the collective bargaining agreement which exceeded the amount of compensation awarded. Although it did not request an adjustment before the referee, it unilaterally treated those payments as contractual workers' compensation benefits and unilaterally "credited" claimant for the amount of disability benefits that it had paid in his absence and paid him only the additional 25 percent penalty ordered by the referee. Claimant sought a hearing, and the referee ordered employer to pay all of the temporary total disability awarded plus an additional 25 percent penalty.

Employer argues that, because claimant has been fully compensated for lost wages, it should not be required to pay additional compensation. *See Fink v. Metropolitan Public Defender*, 67 Or App 79, 676 P2d 934, *rev den* 296 Or 829 (1984). We do not decide whether an employer may substitute negotiated disability benefits in a collective bargaining agreement for benefits which are due under the workers' compensation system. The issue is not whether employer could properly "credit" claimant for disability benefits that it had previously paid if it had requested an adjustment, but whether employer could disregard the referee's order and unilaterally adjust the amount of its payments. It could not. *See Georgia Pacific v. Piwowar*, 86 Or App 82, 85, 738 P2d 225 (1987), *rev pending*.

Affirmed on petition and cross-petition in CA A41734 and on petition in CA A41856.

IN THE COURT OF APPEALS OF THE
STATE OF OREGON

BLACKNALL,
Appellant,
v.
WESTWOOD CORPORATION,
DEVELOPERS AND CONTRACTORS,
dba Westwood Construction Company,
Respondent.
(A8607-03986; CA A43239)

Appeal from Circuit Court, Multnomah County.

Richard Spier, Judge Pro Tempore.

Argued and submitted November 13, 1987.

J. Randolph Pickett, Portland, argued the cause for appellant. With him on the brief was Marlene E. Findling, Portland.

Thomas W. Brown, Portland, argued the cause for respondent. With him on the brief was Cosgrave, Kester, Crowe, Gidley & Lagesen, Portland.

Before Buttler, Presiding Judge, and Warren and Rossman, Judges.

WARREN, J.

Affirmed.

WARREN, J.

This is a tort action. Plaintiff appeals a summary judgment for defendant. The question before us is whether defendant is a "complying employer" pursuant to ORS 656.017 and, as such, immune from tort liability. ORS 656.018.

Neither party disputes these facts. Plaintiff was an employe of Aida Services, Inc. (Aida), a corporation providing temporary labor services. Pursuant to a work order, he was sent to work on defendant's construction project. He carried a time card issued by Aida, which was filled out and signed by defendant's representative on the job site. The card contained a "customer agreement" providing that Aida was plaintiff's employer. Defendant, however, directly supervised and controlled plaintiff's work at the site, including hours, breaks and work assignments, and could terminate his services at any time. Aida paid salary, payroll taxes, workers' compensation insurance, Social Security taxes, unemployment insurance rates and other fringe benefits in respect to plaintiff. It charged defendant an hourly rate for his services. The rate charged by Aida included, *inter alia,* a charge for workers' compensation insurance. While working for defendant, plaintiff sustained personal injuries, for which he has received workers' compensation benefits from Aida's insurer.

The trial court held that Aida and defendant were

dual employers of plaintiff and that defendant, as a "complying employer," was immune from tort liability for plaintiff's injuries. The court granted summary judgment for defendant. Plaintiff argues that the question of whether plaintiff was defendant's employe is a question of fact. The question of a person's employment status is for the trier of fact, if the facts surrounding the arrangement between the parties are in dispute. When there is no dispute, and the parties merely disagree about the legal consequences of the agreed facts, the question is one for the court. *Sugura v. McLaughlin,* 79 Or App 69, 72, 717 P2d 1251, *rev den* 301 Or 338 (1986); *Woody v. Waibel,* 276 Or 189, 192-93 n 3, 554 P2d 492 (1976). The tests for the existence of an employer-employe relationship include the payment of compensation and the right to direct and control. For purposes of worker's compensation, an employe can have more than one employer. ORS 656.005(13) and (27);

Robinson v. Omark Industries, 46 Or App 263, 265-66, 611 P2d 665 (1980), *rev dismissed* 291 Or 5 (1981).

Plaintiff was compensated by defendant through Aida and was subject to defendant's direct control. We agree with the trial court's conclusion that both Aida and defendant were plaintiff's employers.

The next issue is whether defendant was a "complying employer" and thus was immune from tort liability.[1] In *Robinson v. Omark Industries, supra,* we held that a corporation which temporarily employed workers through a temporary services agency was a "complying employer." It paid a fee to the agency for services rendered, and the fee included a charge for workers' compensation insurance that the agency actually maintained. Plaintiff here contends that defendant was not a complying employer, because it paid Aida a flat fee, which was not broken down so as to state a specific change for workers' compensation coverage. Although defendant did not maintain insurance for temporary workers, it is undisputed that the rate paid to Aida for plaintiff's services was computed to include workers' compensation insurance and other payroll costs. That defendant was paying for the workers' compensation premium was known both to Aida and defendant. It is immaterial that Aida did not provide an itemized statement.

Plaintiff asks that we overrule *Robinson v. Omark, supra,* if we find it controlling. Because virtually the same facts are involved here as in *Robinson,* it is controlling. We decline to overrule it, and we hold that defendant complied with ORS 656.017. It is therefore immune from tort liability.

Affirmed.

[1] An employer is "complying" and exempt from any other liability if it obtains insurance or is self-insured. ORS 656. 017(1); ORS 656.018.

IN THE COURT OF APPEALS OF THE
STATE OF OREGON

In the Matter of the Compensation of
Mary McFarland, Claimant.

McFARLAND,
Petitioner,

v.

SAIF CORPORATION et al,
Respondents.

(WCB 83-06254, WCB 84-02929 & WCB 84-04800;
CA A40544)

Judicial Review from Workers' Compensation Board.

Argued and submitted March 11, 1987.

Merrill Schneider, Portland, argued the cause for petitioner. With him on the brief was Merrill Schneider & Associates, Portland.

Darrell E. Bewley, Assistant Attorney General, Salem, argued the cause for respondents SAIF Corporation and Reedwood Extended Care Center. With him on the brief were Dave Frohnmayer, Attorney General, and Virginia L. Linder, Solicitor General, Salem.

Jas J. Adams, Portland, argued the cause for respondents Senior Services Division and SAIF Corporation. With him on the brief was Acker, Underwood & Smith, Portland.

Before Richardson, Presiding Judge, and Newman and Deits, Judges.

RICHARDSON, P. J.

Affirmed.

RICHARDSON, P. J.

Claimant seeks review of a Workers' Compensation Board order that affirmed the referee's denial of her aggravation and industrial injury claims. We affirm.

Claimant received temporary total disability and temporary partial disability payments for an arm injury incurred while employed by Reedwood Extended Care Center in 1981. She was not awarded any permanent disability benefits. In 1983, she injured her shoulder while employed as a domestic servant at a job that she had obtained through the Senior Services Division of the Department of Human Resources (Division). She filed a claim against Reedwood Extended Care Center, alleging that the 1983 injury was an aggravation of the 1981 injury. In a claim against Division and Ms. Dimery, the elderly woman for whom she was caring, she alleged that the 1983 injury was a new injury. SAIF, insurer for Reedwood and Division, denied the claims. After a hearing, the referee found that the medical evidence did not support

the claim for aggravation. Her claims against Division and Dimery[1] were denied on the ground that she was not a subject worker and that the Division and Dimery were not subject employers. The Board affirmed the referee.

The initial issue is whether the 1983 injury was an aggravation or a new injury. Reedwood and SAIF contend that the 1983 injury could not have been an aggravation, because it involved her shoulder, whereas the 1981 injury involved only the elbow. Claimant asserts that the 1981 injury involved the right arm, elbow and shoulder. Although there is some evidence in the record that there was shoulder involvement in 1981,[2] we conclude that the medical evidence does not support

claimant's contention that the 1983 injury was an aggravation.

Two doctors, both orthopedists, concluded that the 1983 injury was not an aggravation. Harris, claimant's treating physician, referred her to Achterman, an orthopedist, who concluded that she had sustained a new injury in 1983, rather than an aggravation of her previous injury. Dr. Puziss, an orthopedist who had also examined claimant after the 1981 injury, described the 1983 incident and injury:

> "[Claimant] was working in a private home 'for the state' and was taking care of a 93 year-old blind, disabled patient and states that when she lifted her, about two months ago, she had been working there about five weeks. This patient weighed about 175 pounds and [claimant] sustained pain about her right biceps area. This pain was causing her to awaken every night. She could not sleep and was very tense. She has not worked since the injury. Initially she had felt pain for about one to three days, worsening over the right shoulder and trapezius area, radiating to the biceps.
>
> "She has had problems with her right upper extremity ever since this time."

He diagnosed right biceps tendonitis and right supraspinatus tendonitis, stating that she had sustained a lifting injury to the right shoulder but that it was open to question as to whether it was an aggravation of a previous tendonitis. He later clarified his diagnosis:

> "It appears that [claimant's] lifting injury sustained as a nurse * * * was the material contributing cause of Ms. McFarland's recent right biceps and supraspinatus tendinitis. You will recall that [claimant] had pain in the right forearm before. This is not the same injury and without any information to the contrary, I can only assume that [her] present complaints are related to the above injury of sometime in March, 1983."

On the other hand, Harris diagnosed an aggravation of her right arm tendonitis and concluded that the 1983 injury was

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[1] Dimery is deceased and has been dismissed as a party.

[2] In his chart notes, Dr. Harris referred to a sprain of the right arm and shoulder in October, 1981, but diagnosed only sprains of the right arm. In November, 1981, he noted some aching in her right arm and shoulder, a sprain of the trapezius and tenderness over the supraspinatus tendon and diagnosed tendonitis and a rotator cuff sprain. When Dr. Puziss examined claimant in September, 1981, he found mild tenderness "over the supraspinatus tendon, deep to deltoid." However, he also found "full active range of motion of both shoulders" and "no tenderness about the shoulder directly." He diagnosed "obscure pain, right volar forearm." The claim form filed by claimant, the initial medical report filed by Harris with the Workers' Compensation Department and the first opinion and order referred to the 1981 injury as only an elbow injury.

an aggravation of the preexisting tendonitis of her arm. Similarly, Dr. McCaffrey, a chiropractor who had examined claimant after the 1983 incident, concluded that the 1983 injury was "directly related to that injury incurred while she was working at the Reedwood Care Center in 1981."

On *de novo* review, we find the evidence presented by

the orthopedic specialists, Achterman and Puziss, persuasive and conclude that the 1983 injury was not related to the 1981 injury. It follows that claimant did not sustain an aggravation of the 1981 injury.

The next inquiry is whether the 1983 injury is compensable as a new injury. ORS 656.027(1)[3] excludes domestic servants from workers' compensation coverage. A worker hired to take care of a person is engaged in domestic service, and the fact that she was certified as a nurse's aide does not change her status as a domestic servant. *Gunter v. Mersereau,* 7 Or App 470, 491 P2d 1205 (1971). Her duties included meal preparation, washing dishes, feeding and bathing Dimery and turning her in her bed every two hours. The duties are those of a domestic servant.

Additionally, *former* ORS 411.590[4] provided that domestic servants of persons receiving public assistance from Division were not subject workers under ORS 656.027 even if the worker was paid by Division rather than the person for whom services were performed. Here, claimant was performing the tasks of a domestic servant and was paid through Division.

We conclude that the Board did not err in holding that Division and Dimery were not subject employers and that claimant was not a subject worker. Her claim for a new injury

from the 1983 incident was not covered by the Workers' Compensation laws and was properly denied.

Affirmed.

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[3] *Former* ORS 656.027 provided, in part:

"All workers are subject to ORS 656.001 to 656.794 except those nonsubject workers described in the following subsections:

"(1) A worker employed as a domestic servant in or about a private home. For the purposes of this subsection 'domestic servant' means any worker engaged in household domestic service."

[4] ORS 411.590 provides:

"A person who is employed as a housekeeper, homemaker or otherwise as a domestic servant in the house of a recipient of public assistance or services, whose compensation is paid in whole or in part by the Adult and Family Services Division, the Senior Services Division or the Children's Services Division and is not otherwise employed by the division, shall not for any purposes be deemed to be an employe of the State of Oregon whether or not the division selects the person for employment or exercises any direction or control over the person's employment. Such person shall be deemed to be a nonsubject worker under ORS 656.027."

The statute was amended by Or Laws 1987, ch 780, § 1.

IN THE COURT OF APPEALS OF THE STATE OF OREGON

In the Matter of the Compensation of Joanne C. Krause, Claimant.

VIP'S RESTAURANT et al,
Petitioners,

v.

KRAUSE,
Respondent.

(WCB 86-05815; CA A42526)

Judicial Review from Workers' Compensation Board.

Argued and submitted October 12, 1987.

Craig A. Staples, Portland, argued the cause for petitioners. With him on the brief was Roberts, Reinisch & Klor, P.C., Portland.

Charles S. Tauman, Portland, argued the cause for respondent. With him on the brief was Bennett, Hartman, Tauman & Reynolds, P.C., Portland.

Before Buttler, Presiding Judge, and Warren and Rossman, Judges.

WARREN, J.

Award of attorney fees reversed; otherwise affirmed.

WARREN, J.

In this Workers' Compensation case, claimant filed a June, 1984, aggravation claim, which employer denied. On February 18, 1986, the referee ordered employer to accept the claim. In the interim, on January 31, 1985, claimant's treating physician determined that she was medically stationary but did not release her for work. She has never challenged that. After the February order, employer paid compensation for temporary total disability only through January 31, 1985.

Claimant sought a hearing, asserting that, because she had not been released for work, she was entitled to temporary total disability benefits until the Evaluation Division had issued a determination order. ORS 656.268(2).[1] In May, 1986, the referee denied the request for additional compensation, stating that employer should not be required to pay time loss during the time when claimant was medically stationary. The

[1] ORS 656.268(2) provides, in part:

"When the injured worker's condition resulting from a disabling injury has become medically stationary, unless the injured worker is enrolled and actively engaged in training, the insurer or self-insured employer shall notify the Evaluation Division, the worker, and the employer, if any, and request the claim be examined and further compensation, if any, be determined. * * * *If the attending physician has not approved the worker's return to the worker's regular employment, the insurer or self-insured employer must continue to make temporary total disability payments until termination of such payments is authorized following examination of the medical reports submitted to the Evaluation Division under this section.*" (Emphasis supplied.)

division issued a determination order on June 6, 1986, ordering payment of temporary total disability benefits from the date of the injury to December 18, 1984, apparently having determined that claimant became medically stationary on that date.

On claimant's appeal, the Board ruled that employer was required to pay time loss from the date of the injury until the division authorized it to terminate benefits. We agree with the Board's determination and conclude that employer was required to pay benefits for temporary total disability through the date of the June 6, 1986, determination order. As we held in *Noffsinger v. Yoncalla Timber Products,* 88 Or App 118, 714 P2d 295 (1987), ORS 656.268 deals with the processing of a claim that is in "accepted" status. Although this claim was originally denied, it became accepted when the referee ordered

it accepted in February, 1986. At that point, employer was obligated to process it as an accepted claim.

ORS 656.268(2) provides that, when a claimant is medically stationary but has not yet been released for work, the employer "must continue" to pay benefits for temporary total disability "until termination of such payments" is authorized by the division. Employer focuses on the quoted language as an indication that the requirement for payment of temporary total disability has no significance in a case such as this, where payments have never been made and therefore cannot "continue" or "terminate." Although the precise wording of the statute is about the processing of a claim accepted at the outset or before the medically stationary date, we conclude that it also applies under the circumstances here. An employer ordered to accept a claim after the medically stationary date should be no less responsible for the payment of temporary total disability benefits than an employer who accepts the claim at the outset or who is ordered to accept the claim while the claimant is temporarily disabled. Because claimant has never been released for work, employer was obligated to pay benefits for temporary total disability until the division's June 6, 1986, order determining that claimant was medically stationary and thereby authorizing the termination of benefits for temporary total disability.

Employer asserts that the application of the statute in these circumstances will result in the payment of benefits greater than those it would have paid had it accepted the claim initially, because the pendency of the litigation on compensability delays the process of claim closure. That is a situation within the control of employer. When an employer denies the compensability of a claim, it takes the risk that that issue may be resolved against it, *i.e.,* that the claim was in fact compensable from the outset. Although an employer is not required to seek closure of a claim that is in "denied" status, nothing prevents it from doing so, for the determination of extent of disability is not stayed during litigation of compensability. *SAIF v. Maddox,* 295 Or 448, 454, 667 P2d 529 (1983). To protect itself, an employer may seek closure of the denied claim when the claimant is determined to be medically stationary, irrespective of the pending litigation on compensability.

Employer assigns error to the Board's award of attorney fees for services performed at the Board and referee levels. The Board determined that, because employer had acted consistently with the Board's order in *Sharon Bracke,* 36 Van Natta 1245 (1984), its failure to pay benefits beyond the medically stationary date was not unreasonable. We agree that employer's conduct was not unreasonable and, therefore, hold that claimant is not entitled to attorney fees under ORS 656.262(10) or ORS 656.382(1). The Board awarded fees to claimant for having prevailed on her claim for additional compensation, and employer argues that it should not have done so, because claimant's attorney filed no brief at the Board level. *See Les Schwab Tire Center v. Elmer's Pancake House,* 84 Or App 425, 734 P2d 13 (1987). Irrespective of that argument, we know of no basis for an award of attorney fees in these circumstances. This case does not meet the criteria of either ORS 656.382(2) or ORS 656.386(1), because the Board appeal was not taken by employer, ORS 656.382(2), or from the denial of compensability. ORS 656.386(1); *see Shoulders v. SAIF,* 300 Or 606, 716 P2d 751 (1986). We therefore reverse the award.

Award of attorney fees reversed; otherwise affirmed.

IN THE COURT OF APPEALS OF THE STATE OF OREGON

In the Matter of the Compensation of Vlassios Damis, Claimant.

DAMIS,
Petitioner,

v.

COTTER & COMPANY et al,
Respondents.

(WCB 85-06061; CA A42156)

Judicial Review from Workers' Compensation Board.

Argued and submitted October 12, 1987.

Robert K. Udziela, Portland, argued the cause for petitioner. With him on the brief were Donald R. Wilson and Pozzi, Wilson, Atchison, O'Leary & Conboy, Portland.

Stephen R. Frank, Portland, argued the cause for respondents. On the brief was Montgomery W. Cobb, Portland.

Before Buttler, Presiding Judge, and Warren and Rossman, Judges.

WARREN, J.

Affirmed.

Rossman, J., dissenting.

WARREN, J.

Claimant seeks review of an order of the Workers' Compensation Board reversing the referee's determination that the injuries he suffered when he fell at work are compensable.

Claimant was working for employer as a loader when he sustained an injury to his head. He originally told doctors that he could not recall falling or his activities immediately before the injury. He testified at the hearing, however, that he remembers picking up a heavy toolbox and twisting to the left; the next thing he remembers is lying on the floor. He does not remember feeling dizzy or nauseous before the event. The evidence is that no one saw him fall and that co-workers found him unconscious on the floor.

Claimant's injury is not compensable if the fall was "idiopathic," *i.e.*, caused by a condition personal to claimant, rather than work-related or "unexplained." *Phil A. Livesley Co. v. Russ*, 296 Or 25, 672 P2d 337 (1983). A fall is "unexplained" if it occurred during the course of employment and was not caused by idiopathic factors. 296 Or at 27. When idiopathic causes have been eliminated, the inference arises that the fall is traceable to some risk, albeit unidentified, to which the employe was exposed at the workplace. 296 Or at 32.

Drs. Wells, Reinhart and Buxman saw claimant immediately after the fall and described the event as a "syncopal episode," a sudden loss of consciousness or a fainting spell, presumably on the basis of claimant's description of the event, particularly his lack of memory of falling. They performed diagnostic tests and eliminated every suspected cause of fainting.

When claimant's counsel asked whether he might not have just tripped and fallen, the doctors expressed uncertainty as to the actual cause of the fall. Wells could not say whether claimant had fainted or had tripped and fallen. Reinhart maintained that his original diagnosis of a faint is consistent with the history that claimant provided. He said, however, that, because there were no witnesses, it would be impossible to define a clear cause of the fall. Buxman stated that he did not know whether claimant had slipped and fallen or had fainted. Dr. Grewe, who did not examine claimant until four

months after the event, stated that, because the studies had not identified a physiological cause for a lapse of consciousness, "I would have to assume that he probably just fell from some mechanical cause."

It appears that, initially, for the sake of diagnosis and treatment, the doctors had understandably assumed, but had not actually determined, that claimant had fainted. Their assumption was consistent with claimant's description of the event and his lack of memory of actually falling. No one disputes claimant's credibility. No one has explained why he would not remember falling if he had not lost consciousness before the fall. No reason has been given why he would not remember if he had tripped. There is no evidence that he did

trip or that the fall was otherwise "mechanical." We find, on *de novo* review, that the most plausible explanation is that he fainted.

The question now becomes essentially indistinguishable from that in *McAdams v. SAIF*, 66 Or App 415, 675 P2d 80, *rev den* 296 Or 638 (1984), where, as here, the evidence was that the cause of the claimant's fall was fainting from an unknown cause. We found that it was as possible that the cause of the faint was idiopathic as that it was work-related and held that the claimant had not met her burden of showing that the faint was not idiopathic. Here, although claimant has eliminated many suspected causes, the evidence is that there are a multitude of additional personal factors that can bring on a faint. He has not, therefore, met his burden of proving that the faint was not idiopathic. Accordingly, we are unable to infer that the faint came about as a result of a work-related but unexplained cause, and the claim is not compensable.

Affirmed.

ROSSMAN, J., dissenting.

Claimant fell and was injured at work. *All* the medical experts agree that there is no objective medical evidence of the cause of his fall. In the words of Dr. Reinhart, a witness for employer, "I think it will be impossible to define a clear etiology for this event."

Phil A. Livesley Co. v. Russ, 296 Or 25, 30, 672 P2d 337 (1983), holds that, if a worker's fall is unexplained, it is

compensable, but if it resulted from idiopathic causes, it is not. The burden of "persuasively" eliminating idiopathic causes is on the claimant. 296 Or at 30. The medical evidence in this case is that many possible idiopathic causes of a fall can *never* be eliminated. Therefore, if "persuasively" eliminating idiopathic causes requires that a claimant must prove that none could exist, *Livesley* is meaningless.

I would hold that a claimant persuasively eliminates idiopathic causes if he eliminates the most probable idiopathic causes of an event, and the remaining possibilities are not capable of being proven or disproven. The majority finds that "the most plausible explanation" of the fall is that claimant fainted. The majority ignores the one clear piece of medical evidence: no one knows why claimant fell. Unfortunately, it then decides the case by making a guess. If that method is to be used to analyze these kinds of cases, it could be that no injury could ever be from "unknown" causes.

The neurologist's explanation of the evidence is most persuasive to me:

> "There is no way of knowing if there was some physiological cause of a lapse of conciousness * * *. In other words, since there is no proof to the contrary, a diagnosis of cerebral concussion, occipital laceraction and cervical strain superimposed on cervical spondylosis (etiology unknown) would be a more appropriate diagnosis."

Claimant eliminated discernable heart and neurological problems as the cause. Employer's witness could not even identify

the most probable among other possible, unascertainable causes. The cause of claimant's fall was unknown. He should receive benefits.

IN THE COURT OF APPEALS OF THE STATE OF OREGON

ARNOLD,
Respondent,
v.
BURLINGTON NORTHERN RAILROAD COMPANY,
Appellant.
(A8502-01021; CA A39775)

Appeal from Circuit Court, Multnomah County.

Harl H. Haas, Judge.

Argued and submitted May 26, 1987.

Robert E. Barton, Portland, argued the cause for appellant. With him on the briefs was Cosgrave, Kester, Crowe, Gidley & Lagesen, Portland.

Thomas M. Christ, Portland, argued the cause for respondent. With him on the brief was Monte Bricker, Zig Zakovics and Bricker, Zakovics & Querin, P.C., Portland.

Before Richardson, Presiding Judge, and Newman and Deits, Judges.

NEWMAN, J.

Affirmed.

NEWMAN, J.

Defendant appeals a $1,900,375 judgment for plaintiff, its employe, in this action under the Federal Employer's Liability Act, 45 USC § 51 *et seq* (1976). We affirm.

Plaintiff suffered a traumatic amputation of both legs when a railroad car struck him while he was clearing snow from a switch in defendant's railroad yard. Defendant admitted liability. The issue was the amount of general damages. Plaintiff presented evidence of the cost of his future medical treatment and related services, loss of earning capacity and pain and suffering. The evidence included testimony that plaintiff's prosthetic legs would need to be replaced periodically, that he would never be able to live independently and that he would require future physical therapy, especially as he aged. He also showed a videotape of himself engaged in representative daily activities.

Defendant assigns as error that the court denied its motion, at the close of plaintiff's case, to strike plaintiff's claim for damages for future physical therapy. The principal evidence in support of the claim was the testimony of his vocational rehabilitation expert that plaintiff would need physical therapy indefinitely. Defendant asserts that the evi-

dence of plaintiff's need for future physical therapy was insufficient because, like prescriptions or other medical treatment, the need must be established by expert medical testimony from a physician.

Defendant concedes that the vocational rehabilitation expert was qualified to testify to plaintiff's *need* for physical therapy, although he could not *prescribe* that treatment.[1] The extent of plaintiff's need for that treatment was the central issue. Plaintiff's treating physician did not testify that plaintiff would not require any physical therapy in the future. He testified that the frequency of plaintiff's physical therapy sessions could be reduced immediately and eventually stopped if plaintiff could maintain his physical condition and strength through exercises at home. There was, therefore, conflicting evidence as to the amount of physical therapy that plaintiff

would need in the future. The court did not err when it denied defendant's motion. *See Martin Engineering v. Opton*, 277 Or 291, 295-96, 560 P2d 617 (1977).

Defendant assigns as error that the court did not give defendant's requested jury instruction to reduce to present value plaintiff's damages for future pain and suffering.[2] The court did not err. The damages should not be so reduced. *Blankenship v. Union Pacific Railroad Co.*, 87 Or App 410, 414, 742 P2d 680, *recon den by opinion* 89 Or App 31, ___ P2d ___ (1987).

Finally, defendant assigns as error that the court, over defendant's objection, admitted in evidence a videotape that showed plaintiff doing supposedly representative daily activities. It was not a film of an actual day in plaintiff's life. It was 27 minutes long and was shown in three segments without a sound track. In it, plaintiff put on his prosthetic legs, drove his specially equipped truck, fell, grimaced with pain and crossed a street while the pedestrian light changed. Between each segment, plaintiff testified to what had been shown in the film and to the frequency of the occurrences. Defendant contends that the film is non-verbal hearsay, selective, self-serving and cumulative and that its prejudicial impact outweighed its probative value. OEC 403.

It is not hearsay. It is demonstrative evidence that plaintiff offered to illustrate and supplement his testimony. He testified to its accuracy, and he was subject to cross-examination.

Although the videotape was selective and self-serving, much relevant evidence is of that character. It was cumulative to some extent, because it depicted events to which plaintiff and other witnesses testified; however, it also com-

[1] Defendant cites no cases which hold that a vocational rehabilitation expert is incompetent to testify to the need for physical therapy. *See Annots.*, 69 ALR 2d 1261 (1960); 45 ALR 2d 1148 (1956).

[2] The requested instruction provided:

"In making any award for any damage or loss which you find will be incurred in the future, you must take into account the fact that the money awarded by you is being received all at one time instead of over a period of time extending into the future and that plaintiff will have the use of this money in a lump sum. You must, therefore, determine the present value or present worth of the money which you award for such future loss."

municated to the jury effectively, and perhaps better than words could do, what plaintiff's life as a double amputee was like.

The trial court believed that the probative value of the film—its ability to illustrate graphically the impact of plaintiff's injuries on his life—outweighed its prejudicial value—the danger of eliciting undue sympathy for the plaintiff. We review for abuse of discretion. *See Carter v. Moberly,* 263 Or 193, 200, 501 P2d 1276 (1972); *Pooschke v. U.P. Railroad,* 246 Or 633, 642, 426 P2d 866 (1967). We find none.

Affirmed.

IN THE COURT OF APPEALS OF THE STATE OF OREGON

In the Matter of the Compensation of Richard G. Surprise, Claimant.

WEYERHAEUSER COMPANY,
Petitioner - Cross-Respondent,

v.

SURPRISE,
Respondent - Cross-Petitioner.

(WCB 85-03495; CA A42210)

Judicial Review from Workers' Compensation Board.

Argued and submitted October 16, 1987.

Paul L. Roess, Coos Bay, argued the cause for petitioner - cross-respondent. With him on the brief was Foss, Whitty & Roess, Coos Bay.

James L. Edmunson, Eugene, argued the cause for respondent - cross-petitioner. With him on the brief were Karen M. Werner and Malagon & Moore, Eugene.

Before Warden, Presiding Judge, and Joseph, Chief Judge,* and Van Hoomissen, Judge.

WARDEN, P. J.

Affirmed on petition; on cross-petition, Board order upholding closure by determination order of March 28, 1985, reversed; referee's award of penalties and attorney fees for improper claim closure of November 28, 1984, reinstated; otherwise affirmed.

* Joseph, C. J., *vice* Young, J., deceased.

WARDEN, P. J.

Employer seeks review of a Workers' Compensation Board order which affirmed the referee in setting aside employer's denial of responsibility for claimant's treatment at a pain center and ordering employer to pay temporary total disability (TTD) for the period of claimant's treatment.

Claimant, in his cross-petition, seeks review of the Board's reversal of a portion of the referee's order which had awarded penalties and attorney fees for employer's allegedly improper claim closure, of the Board's reduction of his unscheduled permanent partial disability (PPD) award from 20 percent to 10 percent and of the Board's refusal to set aside the Evaluation Division's allegedly premature closure of the claim. We affirm on the petition; on the cross-petition, we reverse in part.

In May, 1983, claimant injured his lower back when he slipped in an oil puddle at work. Dr. Bert, an orthopedist, treated him; Dr. Bernstein, a neurologist, also saw him once for a consultation. In December, Bert performed a laminectomy and partial diskectomy at the L4-5 level. Claimant's recovery was uneventful. In October, 1984, Bert reported that claimant had permanent limitations with respect to lifting, carrying, bending, squatting, climbing, crawling and reaching. In November, however, Bert reported that claimant had made a complete recovery with only minimal discomfort in his back. He released claimant for work with no restrictions as of November 19, 1984.[1]

On November 28, 1984, employer sent claimant a Notice of Claim Closure, advising him that he was entitled to an award of TTD from June 1, 1983 to November 16, 1984, but that he was not entitled to an award of PPD. In December, 1984, claimant saw Bernstein, complaining of lower back pain. Bernstein wrote employer and suggested that claimant be retrained for lighter work. He limited claimant to lifting and carrying no more than 10 pounds on a regular basis, with occasional lifting and carrying of 20 pounds. Claimant saw Bernstein several times over the next few months and

received various forms of conservative treatment, including pain medication and the application of heating pads. In March, 1985, Bernstein reported that it was "time that we start thinking in terms of pain clinic referral."

The Evaluation Division reviewed employer's notice of claim closure pursuant to ORS 656.268(3)[2] (since *amended by* Or Laws 1987, ch 884, § 10). On March 28, 1985, it issued a determination order awarding claimant TTD from May 31, 1984, through November 18, 1984, and five percent unscheduled PPD for his lower back.

Bernstein referred claimant to the Western Pain Center in Roseburg. Employer, however, denied responsibility for the program on the ground that it was not reasonable and necessary treatment. Claimant nevertheless participated in the program from May 20, 1985, through June 6, 1985, and his condition improved significantly.

Claimant sought a hearing on the extent of PPD, employer's denial of responsibility for the WPC treatment

[1] Claimant did not actually return to work, despite having been declared medically stationary, because employer had sold the mill where he had been employed and there was no work to which he could return.

[2] The record does not directly indicate that claimant requested review by the Evaluation Division. However, a request for review from a claimant is the only statutory basis for Evaluation Division involvement.

and his claim for penalties and attorney fees for employer's allegedly improper closure of the claim. The referee increased the PPD award to 20 percent and found for claimant on the other issues as well. The Board reduced the PPD award to 10 percent and denied penalties and attorney fees for employer's claim closure. On review, employer contends that the Board erred in finding the pain center program to be reasonable and necessary treatment. On *de novo* review, we agree with the referee and the Board that the treatment was both reasonable and necessary.

Employer also contends that the Board erred in awarding claimant TTD for the period during which he was treated at the pain center, because claimant was released to return to all usual and customary work with no impairment as of November 19, 1984. We disagree. A worker is entitled to TTD during periods of total disability. ORS 656.210(1); *see Gwynn v. SAIF,* 304 Or 345, 745 P2d 775 (1987). Claimant began to see Bernstein soon after Bert released him for work, because of his continuing pain, and, at Bernstein's suggestion,

he eventually entered a treatment program which required full-time participation. That participation rendered him unavailable for work. *See Smith v. SAIF,* 302 Or 396, 400-401, 730 P2d 30 (1986). We need not find that claimant was physically unable to do his customary work if he had been available. As the referee said:

> "[D]uring this time claimant would not have been able to work at the job he held at the time of his injury, either at Weyerhaeuser (if the mill had been open) or elsewhere * * *. I find the Pain Center treatment to be compensable. Thus, claimant is entitled to [TTD] during the period of this treatment."

Employer would have us distinguish between a claimant who is *physically unable* to work and one who, because of necessary treatment, is unavailable to go to work. We refuse to do so. A claimant who must undergo full-time treatment is physically unable to have regular employment at the same time. When the treatment is a consequence of a compensable injury, that physical inability is also a result of the injury. The purpose of TTD is to replace income lost as a result of injury; to deny it in these circumstances would defeat the statutory purpose.[3] Because, as we hold below, the closure of March 18, 1985, was premature, there is no issue of whether the PPD award contemplated this period of temporary disability. *See Gwynn v. SAIF, supra,* 304 Or at 352-353.

On cross-petition, claimant asserts that the Board erred in reversing the referee's award of penalties and attorney fees for employer's alleged improper claim closure. The referee held that Bert's November 14, 1984, report would have constituted substantial evidence in support of closure but for the claimant's back surgery. The referee stated:

> "Pursuant to [OAR 436-30-490(2)(a)] [the laminectomy and partial diskectomy] *in and of itself* constituted the basis for some permanent impairment which, along with the non-

[3] The legislature has resolved this issue for future cases. ORS 656.210(4), effective January 1, 1988, provides that a worker is entitled to TTD for treatment-related absences from work of four hours or more, unless the employer pays wages for the period of absence.

medical factors that are considered in rating unscheduled permanent partial disability, would entitle claimant to a permanent partial disability award at the Evaluation Division level." (Emphasis supplied.)

Although the guidelines for rating PPD in the administrative rules do not control the decision of a referee, the Board, or this court, *SAIF v. Baer,* 61 Or App 335, 337, 656 P2d 959, *rev den* 294 Or 749 (1983), they *do* control the Evaluation Division. By issuing its own closure, employer placed on claimant the burden of obtaining a PPD award from the Division when employer should have known that claimant was entitled to one. When the Division did order an award, employer did not challenge it. There was no substantial evidence that the claim could be closed without an award of PPD before review by the Division. The referee correctly awarded penalties and attorney fees. *Former* ORS 656.268(3) (*amended by* Or Laws 1987, ch 884, § 10); *see Volk v. SAIF,* 73 Or App 643, 700 P2d 673 (1985).

Claimant also seeks review of the Board's reduction in the PPD awarded him by the referee. We see no reason to disagree with the Board's evaluation and therefore affirm.

Finally, claimant attacks the March 18, 1985, claim closure as premature. As employer notes, if the pain center treatment was reasonable and necessary in order for his condition to improve, the closure was premature. At the time of closure, claimant had continuing and disabling pain; the treatment significantly reduced it. We have found the treatment to be compensable and, therefore, we reverse the Board's action upholding the closure.[4]

Affirmed on petition; on cross-petition, Board order upholding closure by the determination order of March 28, 1985, reversed; referee's award of penalties and attorney fees for improper claim closure of November 28, 1984, reinstated; otherwise affirmed.

[4] We agree with the referee that claimant has not shown an entitlement to TTD from November 19, 1984, to May 19, 1985, despite the premature claim closure.

IN THE COURT OF APPEALS OF THE STATE OF OREGON

In the Matter of the Compensation of Ronald G. Hansen, Claimant.

HANSEN,
Petitioner,

v.

WEYERHAEUSER COMPANY,
Respondent.

(WCB 83-03734, 84-09893; CA A41772)

Judicial Review from Workers' Compensation Board.

Argued and submitted June 8, 1987.

Michael R. Stebbins, North Bend, argued the cause for petitioner. With him on the brief was Hayner, Stebbins & Coffey, North Bend.

Paul L. Roess, Coos Bay, argued the cause for respondent. With him on the brief was Foss, Whitty & Roess, Coos Bay.

Before Warden, Presiding Judge, and Joseph, Chief Judge, and Van Hoomissen, Judge.

JOSEPH, C. J.

Remanded for payment of medical benefits for the period November 26 to December 13, 1984, at the Western Pain Center; otherwise affirmed.

JOSEPH, C. J.

In this workers' compensation case, claimant seeks review of a Board order which held his pain center treatment and alcohol rehabilitation non-compensable, denied any increase in his awards for scheduled right knee disability or unscheduled low back disability and held that his claim was not prematurely closed. We affirm in part and reverse in part.

Claimant injured his knee on June 9, 1981. His claim was closed on December 13, 1982, and he was awarded 25 percent scheduled permanent partial disability benefits. He returned to work for the same employer in a different capacity. He injured his back on May 4, 1983. As a result of that injury, he spent approximately a month at the Callahan Center in residential treatment, but he made no progress. He then enrolled in Western Pain Center from May 7 to 22, 1984, for treatment of "psychogenic pain syndrome." At the time of his discharge, a staff doctor indicated that further treatment at the pain center would be appropriate. Employer refused to authorize a second stay at the center until claimant had been seen again by his treating physician. On August 17, 1984, that doctor reported him to be medically stationary, but made no comment about a referral to the pain center. The claim was closed in September, 1984, with a 10 percent award for unscheduled low back disability.

Claimant enrolled for a second stay at the pain center

without employer approval on November 26, 1984. Two weeks into his stay, it was discovered that he is an alcoholic. Pain center personnel stated that the first treatment had been unsuccessful because of the alcoholism and that he had to deal with that problem first. Accordingly, claimant took part in a Veterans' Administration alcohol rehabilitation program from December, 1984, to February, 1985. In early February, employer denied responsibility for the alcohol rehabilitation program as well as the second pain center stay. By the end of February, claimant, after retraining and vocational rehabilitation, had found a Forest Service position which entailed desk work and standing and dealing with customers.

The referee increased claimant's scheduled permanent partial disability for his right leg to 35 percent, upheld the denial of compensation for the pain center treatment and the alcohol rehabilitation program and increased the award

for the back disability to 20 percent. The Board upheld the referee's decision, but made an additional award of unscheduled disability of 10 percent for claimant's arthritic right hip.

This case involves an industrial injury and a preexisting condition, alcoholism, which arguably became symptomatic only after claimant's compensable injuries. Because we are not concerned with the compensability of the alcoholism as an occupational disease, the rule in *Weller v. Union Carbide*, 288 Or 27, 602 P2d 259 (1979), does not apply, and claimant need not show a worsening of an underlying condition. Treatment for the alcoholism would be compensable if the injury caused it to become symptomatic, *Barrett v. D & H Drywall*, 300 Or 553, 555, 715 P2d 90 (1987); *see also Grace v. SAIF*, 76 Or App 511, 516, 709 P2d 1146 (1985), or caused a preexisting psychological condition to become symptomatic in the form of alcoholism. *Globe Machine v. Yock*, 79 Or App 9, 15, 717 P2d 1235 (1986). Claimant argues that the Board erred in ruling that the alcohol treatment was not a compensable consequence of his on-the-job injuries. He argues that the pain of his injuries caused him to drink heavily and that, as a result, he became an alcoholic who required treatment. He must prove by a preponderance of the evidence that his on-the-job injury caused the alcoholism. *See Grace v. SAIF, supra*, 76 Or App at 517; *Matthews v. Louisiana Pacific*, 47 Or App 1083, 1085, 615 P2d 1151 (1980).

Claimant depends on opinions by pain center staff and Dr. Emori, a rheumatologist, to prove that the pain of his injuries caused him to become an alcoholic. He relies on the assessment by the pain center's counselor to prove that he had used alcohol to cope with the pain of his injuries and that alcohol treatment was necessary for him to become functional again. As the referee said, the counselor was not competent to render an opinion on the cause of alcoholism. His only function was to determine whether claimant had an alcohol problem, not the cause of the problem. Claimant also relies on the counselor to prove that he had no alcohol problem before his injury. The referee found that, although the counselor used a lengthy questionnaire, he did not ask questions relative to causation of the alcoholism and based his conclusion on incomplete information. We agree.

Claimant also argues that the reports of the pain center's administrator and the staff physician, and the testimony of the administrator, prove that his alcoholism is directly related to the pain from his injuries. At the hearing, the referee, on the basis of the administrator's demeanor, determined that her credibility and reliability were diminished.[1] That finding affects the weight which we give to her testimony and the medical report submitted by the pain center. We, too, are unpersuaded by that evidence.

Claimant initially described his alcohol use as rare or occasional. He did not advise any physician or counselor about it until he entered the alcohol rehabilitation program in December, 1984. However, the record shows earlier evidence of alcoholism. During his stay at the Veterans' Administration facility, claimant admitted that he had had a drinking problem for at least three and one-half years, if not longer, and that he had once been active in Alcoholics Anonymous. He had also participated in a diversion program after being charged with driving under the influence. In light of all the evidence, we find that claimant's alcoholism was preexisting. It was not caused or made symptomatic by his injuries. His claim for compensation for the alcohol rehabilitation program is denied.

Claimant also argues that his claim was prematurely closed, because he was not medically stationary in August, 1984. The claim was prematurely closed only if the alcohol rehabilitation program is compensable, which it is not. Consequently, his claim was not prematurely closed.

Claimant next asserts that the Board erred in failing to find the second stay at the pain center compensable. All expenses of reasonable and necessary treatment are to be paid by the employer for such a period of time as the compensable injury, illness or process of recovery requires, even after a determination of permanent partial disability, and for as long as the life of the claimant. ORS 656.245; *see Denney v. Hallmark Fisheries*, 88 Or App 409, 412, 745 P2d 803 (1987); *Van Blokland v. OHSU*, 87 Or App 694, 698, 743 P2d 1136 (1987).

Medical treatment is compensable if the injury continues to be a material contributing cause of the need for treatment. *Jordan v. SAIF*, 86 Or App 29, 32, 738 P2d 588 (1987). In response to an inquiry by claimant's attorney, the treating physician, Bert, indicated that the follow-up visit at the pain center was reasonable and necessary and that it was related to claimant's injuries. We accept that conclusion and, therefore, find that the second pain center stay is compensable.

We find no reason to increase claimant's benefits for either his right knee or his back.

Remanded for payment of medical benefits for the period November 26 to December 13, 1984, at the Western Pain Center; otherwise affirmed.

[1] The referee concluded that the pain center staff had an adversarial attitude toward employer and that the reliability of the reports on claimant's second stay at the pain center were compromised by the center's attempt to justify both that stay and its failure to identify claimant's alcoholism sooner.

IN THE COURT OF APPEALS OF THE
STATE OF OREGON

In the Matter of the Compensation of
Martin E. Tripp, Claimant.

TRIPP,
Petitioner,

v.

RIDGE RUNNER TIMBER SERVICES et al,
Respondents.

(WCB 84-11895 & WCB 85-01028; CA A40342)

Judicial Review from Workers' Compensation Board.

Argued and submitted April 20, 1987.

James L. Edmunson, Eugene, argued the cause for petitioner. With him on the brief was Malagon & Moore, Eugene.

Marcus K. Ward, Elmira, argued the cause and filed the brief for respondent Ridge Runner Timber Services.

Darrell E. Bewley, Assistant Attorney General, Salem, argued the cause for respondents Briarwood Assoc. and SAIF Corporation. With him on the brief were Dave Frohnmayer, Attorney General, and Virginia L. Linder, Solicitor General, Salem.

Before Richardson, Presiding Judge, and Newman and Deits, Judges.

RICHARDSON, P. J.

Reversed; referee's order reinstated.

RICHARDSON, P. J.

Claimant seeks review of an order of the Workers' Compensation Board denying him benefits for a knee condition. The Board reversed the decision of the referee that the condition was an occupational disease and that Ridge Runner Timber Services was the responsible employer. The Board's holding rests on its conclusion that claimant's knee ailment is not an occupational disease but is merely symptomatic of a preexisting condition. We reverse.

Claimant has been a tree planter since 1977 and began working for Ridge Runner in January, 1983. He developed leg cramping after less than a month of work and consulted Dr. Fergusson, who diagnosed tendonitis of the upper leg and instructed claimant to perform only light work for three days and then to resume his regular duties. He filed a claim with Ridge Runner which was accepted as non-disabling.

Claimant's knee pain, which was ultimately determined to be unrelated to the leg cramps, eventually caused him to leave Ridge Runner on October 27, 1983. Two weeks later, he began work for Briarwood Association, where he was a grounds keeper until April 20, 1984. He attempted to return to Ridge Runner in May, 1984, but worked only two weeks

before knee pain forced him to quit. He filed a claim with Ridge Runner in September, 1984, asserting that his employment as a tree planter caused or aggravated his knee condition and resulted in his need for medical services. The claim was treated as an aggravation of the leg cramping condition and denied by Ridge Runner's insurer, SAIF, on July 16, 1985. A claim against Briarwood for the knee condition was also denied by the same insurer.[1]

The referee concluded that claimant's employment at Ridge Runner had caused his knee condition and awarded benefits for an occupational disease. He noted no relevant preexisting injury. The Board reversed, characterizing claimant's knee pain as merely symptomatic of an existing condition and relying on the Supreme Court's holding in *Weller v. Union Carbide*, 288 Or 27, 602 P2d 259 (1979).

Claimant's condition has defied ready medical diagnosis. Dr. Larson, an orthopedist, initially diagnosed a meniscus tear, but x-rays and an arthrogram did not reveal "any internal derangement." He subsequently diagnosed the condition as an "overuse syndrome" and recommended that claimant pursue a less strenuous vocation. Dr. Wichser, a general practitioner and claimant's treating physician, also initially diagnosed a meniscus tear or a femoral patellar compression syndrome. Because Wichser did not offer another opinion after the arthrogram and x-rays, it is unclear what theory he presently urges as the source of claimant's discomfort. Despite these diagnostic difficulties, both Larson and Wichser attribute claimant's knee pain to the extensive stooping, bending and movement over uneven ground involved in his employment as a tree planter. No underlying metabolic disease or condition has been detected.

Ridge Runner argues that the Board correctly analyzed the facts and that, if claimant has a knee condition, it predates his employment with Ridge Runner. If the condition preexisted his employment, claimant must establish that the work environment worsened the underlying condition and did not just make it symptomatic. The Board's finding that claimant's knee condition preexisted his employment at Ridge Runner by six months is apparently based on claimant's testimony and a reference in Larson's medical reports. Claimant testified on direct and cross-examination about when he had begun work at Ridge Runner and when the knee pain began. He was confused about the beginning date of his employment, but the sense of his testimony was that the knee pain began after he started work with Ridge Runner. His testimony, which the referee found to be credible, relates the pain to carrying loads of tree seedlings up and down inclines and rough terrain. The medical evidence is that tree planting work is the major contributing cause of his knee pain. We conclude that claimant has an occupational disease and that Ridge Runner is the responsible employer.

Reversed; referee's order reinstated.

[1] SAIF is the insurer for both employers. Ridge Runner is represented by separate counsel.

IN THE COURT OF APPEALS OF THE
STATE OF OREGON

In the Matter of the Compensation of
Cherryl Ann Fromme, Claimant.

FROMME,
Petitioner,

v.

FRED MEYER, INC.,
Respondent.

(WCB 85-10042; CA A42360)

On petitioner's objection to respondent's cost bill filed on November 19, 1987.

David C. Force, Eugene, for petitioner.

Deborah L. Sather and Moscato & Byerly, Portland, for respondent.

Before Warden, Presiding Judge, and Warren and Deits, Judges.

WARDEN, P. J.

Objection to cost bill denied. Costs allowed in the amount of $217.

WARDEN, P. J.

In this workers' compensation case, claimant objects to the cost bill filed by employer. On the merits, we affirmed without issuing an opinion. *Fromme v. Fred Meyer, Inc.*, 88 Or App 306, 744 P2d 1366 (1987). We deny the objection and allow costs to employer in the amount of $217.

In *Compton v. Weyerhaeuser Co.*, 302 Or 366, 730 P2d 540 (1986), the court held that costs on judicial review may be assessed against a claimant in a workers' compensation case. The legislature subsequently enacted Or Laws 1987, ch 250, § 4, which amended ORS 656.236(2) by adding the emphasized language, ostensibly to overrule *Compton*:[1]

> "[N]one of the cost of workers' compensation to employers under ORS 656.001 to 656.794, *or in the court review of any claim therefor,* shall be charged to a subject worker." (Emphasis supplied.)

Claimant relies on the amendment in contending that we lack authority to assess costs against her. However, the effective date of Or Laws 1987, ch 250, § 4, was September 27, 1987, and the petition for review in this case was filed in December, 1986. We must decide, therefore, whether the 1987 amendment is to be applied retroactively or only prospectively.

[1] We say "ostensibly," because it is not clear that the word "cost" in ORS 656.236(2) means the same thing as "costs" as used in legal terminology. However, because we decide that the 1987 amendment to ORS 656.236(2) applies only prospectively from its effective date, we need not reach the issue of whether it actually overrules *Compton v. Weyerhaeuser Co., supra.* We note, however, if "cost" in ORS 656.236(2) means "costs," it meant that before *Compton* and, therefore, that case was wrongly decided. In that event, the 1987 amendment is meaningless.

The intent of the legislature governs whether a legislative provision should be given retroactive effect. *Whipple v. Howser,* 291 Or 475, 480, 632 P2d 782 (1981). "Rules" of statutory construction are to be applied in the interpretation of statutes only when the legislative intent has not been expressed. *Whipple v. Howser, supra,* 291 Or at 487 n 6; *see Perkins v. Willamette Industries,* 273 Or 566, 570-71, 542 P2d 473 (1975). Those rules, including the rule concerning the distinction between "procedural" and "substantive" law,[2] are

not conclusive but only serve as guides to interpreting statutes. *Perkins v. Willamette Industries, supra,* 273 Or at 571.

The legislature did not express whether it intended the 1987 amendment to apply retroactively. The legislature did not specify to which cases the amendment is applicable, and it specified no effective date. The amendment ostensibly affects a substantive change in the prior law by depriving employers of the right to be awarded costs and by protecting claimants from having costs assessed against them. *See* n 1, *supra.* The procedural-substantive distinction, *see* n 2, *supra,* suggests that the amendment be applied only prospectively. Furthermore, we believe that the legislature, in enacting so substantial a change in the law, would have made its intention known, if it had intended the change to apply retroactively.[3] *See Perkins v. Willamette Industries, supra,* 273 Or at 571. We accordingly conclude that the legislature intended Or Laws 1987, ch 250, § 4, to apply prospectively from its effective date, September 27, 1987. It follows that the rule in *Compton v. Weyerhaeuser Co., supra,* governs this case, and employer is entitled to an award of costs.

Objection to cost bill is denied. Costs allowed in the amount of $217.

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[2] "Procedural" law prescribes the method of enforcing a right or obtaining a remedy for its invasion; "substantive" law creates, defines and regulates rights. *Long v. Storms,* 52 Or App 685, 687, 629 P2d 827 (1981). Procedural statutes are generally applied retroactively; substantive statutes are generally applied only prospectively. *See Perkins v. Willamette Industries, supra,* 273 Or at 570-71.

[3] We also note that, had the legislature intended any sort of immediate effect, it would have attached an emergency clause instead of letting the statute come into effect only after 90 days after adjournment.

IN THE COURT OF APPEALS OF THE
STATE OF OREGON

In the Matter of the Compensation of
Dwayne L. Varner, Claimant.
STATE ACCIDENT INSURANCE FUND
CORPORATION et al,
Petitioners,
v.
VARNER,
Respondent.
(WCB 85-12134; CA A42724)

Judicial Review from Workers' Compensation Board.

Argued and submitted November 2, 1987.

Darrell E. Bewley, Assistant Attorney General, Salem, argued the cause for petitioners. With him on the brief was Dave Frohnmayer, Attorney General, and Virginia L. Linder, Solicitor General, Salem.

James L. Edmunson, Eugene, argued the cause for respondent. With him on the brief were Karen M. Werner and Malagon & Moore, Eugene.

Before Buttler, Presiding Judge, and Warren and Rossman, Judges.

WARREN, J.

Affirmed.

WARREN, J.

Employer seeks review of a decision of the Workers' Compensation Board determining that claimant's stress-related mental condition is compensable. We affirm.

Claimant began to experience symptoms of stress after he was disciplined in his employment and demoted. Employer relies on *Elwood v. SAIF,* 298 Or 429, 693 P2d 641 (1985), to support its argument that stress which arises out of legitimate and fairly imposed discipline should not be compensable as a matter of law. The Supreme Court held that the legislature did not intend to make illness from losing a job a compensable risk of the job. 298 Or at 433. The court distinguished between the stress of actual or anticipated unemployment, which it held is not compensable, and the stress resulting from the circumstances and manner of discharge, which it held "can be regarded as events still intrinsic to the employment relationship before termination and can lead to compensation." As the court undoubtedly perceived, it would be ironic to compensate an individual for an illness caused by the severance of the employment relationship when it is the existence of the employment which gives rise to the right to compensation in the first place.

In our view, employe discipline is distinguishable from discharge in that employe discipline is intrinsic to the

employment relationship and presumably is imposed with the goal of improving performance. The court stated in *Elwood:*

> "If an employe is demoted and develops a mental illness as a result of the events of the demotion or the changed status or assignment, it would be difficult to argue that the illness was not 'work connected' * * *." 298 Or at 433.

We conclude that, if claimant's discipline was objectively stressful, it could give rise to a claim for a stress-related occupational disease.

The medical evidence shows that claimant has a preexisting psychological problem that predisposed him to stress-related mental illness. In Dr. Holland's opinion, the disciplinary activities resulted in a temporary aggravation of that preexisting condition, but did not worsen the underlying condition. In Dr. Henderson's opinion, claimant's preexisting disorder "materially worsened" as a result of vocational stress.

The Board held that our opinion in *Adsitt v. Clairmont Water District,* 79 Or App 1, 717 P2d 1231, *rev den* 301 Or 338, 301 Or 666 (1986), requires as a matter of law that claimant's worsened symptoms be considered a worsening of the underlying psychological condition and that the claim is therefore compensable. *See Weller v. Union Carbide,* 288 Or 27, 602 P2d 259 (1979). In *Adsitt,* we expressed our dissatisfaction with the adequacy of the legal terminology used to evaluate a stress-related occupational disease claim based on a worsening of a condition which preexisted the employment. We concluded:

> "Although there may be a distinction in a physical disease between an increase in symptoms and a worsening of the underlying condition, nothing in the record suggests a physical component to claimant's problems. We can find no basis for a distinction between the symptoms of a mental disorder and the disorder itself; if the symptoms are worse, the disorder has necessarily worsened, at least until the symptoms abate. The exacerbation of claimant's condition therefore constituted a worsening of her disease." 79 Or App at 7. (Citation omitted.)

Our dissatisfaction with the legal distinction between "symptoms" and "conditions" in the mental illness context persists. Although we recognize that questions of medical causation are not to be decided as a matter of law but must be based on the medical evidence, *Bales v. SAIF,* 294 Or 224, 235, 656 P2d 300 (1982), we stand by our holding in *Adsitt* that, in the absence of a satisfactory medical explanation of a distinction between symptoms and the condition, the symptoms are the condition. Here, although Holland ventured a distinction between an underlying disorder and its symptoms,[1] the explanation is not satisfactory. On *de novo* review, we affirm the Board's decision that claimant's condition is compensable.

Affirmed.

[1] Holland reported:

> "The question you ask [whether claimant's symptoms represent a worsening of the underlying condition] is extremely difficult to answer since there are no objective criteria of psychiatric illness by which to judge the worsening of an underlying condition. Psychiatric disorders are made up primarily of clinically significant behavorial or psychological syndromes or patterns that occur in an individual, and are typically associated with a painful symptom or impairment in one or more areas of functioning."

IN THE COURT OF APPEALS OF THE
STATE OF OREGON

In the Matter of the Compensation of
John K. Eder, Deceased,
for the Benefit of
Jane Eder, Claimant.

EDER,
Petitioner,

v.

PILCHER CONSTRUCTION et al,
Respondents.

(WCB 85-09171; CA A42239)

Judicial Review from the Workers' Compensation Board.

Argued and submitted December 4, 1987.

Robert K. Udziela, Portland, argued the cause for petitioner. With him on the brief were Jeffrey S. Mutnick and Pozzi, Wilson, Atchison, O'Leary & Conboy, Portland.

Michael G. Bostwick, Portland, argued the cause for respondents. On the brief were Richard Wm. Davis and Davis, Bostwick, Scheminske & Lyons, Portland.

Before Buttler, Presiding Judge, and Warren and Rossman, Judges.

WARREN, J.

Affirmed.

WARREN, J.

In this workers' compensation case, claimant seeks review of an order by the Workers' Compensation Board dismissing employer's request for review. The issue is whether the Board retains jurisdiction to review a referee's order when the requesting party withdraws its request to review, after the responding party, without filing a timely cross-request, questions the validity of the referee's order.

Claimant's husband died on May 29, 1985, from ventricular fibrillation, which was a result of his compensable condition. On June 20, 1986, a referee awarded 100 percent unscheduled permanent partial disability and costs of medical services on the deceased husband's claim but denied her widow's benefits.

Employer timely requested review of the order. On October 1, 1986, after the time for cross-request had expired, claimant filed a brief in which she raised the issue of her eligibility to receive widow's benefits. Employer then withdrew its request and moved for dismissal. The Board granted the motion, and claimant appeals.

She relies on *Neely v. SAIF*, 43 Or App 319, 602 P2d 1101 (1979), *rev den* 288 Or 493 (1980), which holds that a party need not cross-petition for review and that the Board

may reach on *de novo* review an issue first raised in briefs before it. Employer contends that, by withdrawal of the request for review, the Board was deprived of its jurisdiction to review, and the case was properly dismissed. It relies on *R.A. Gray & Company v. McKenzie,* 57 Or App 426, 645 P2d 30, *rev den* 293 Or 340 (1982), which holds that a respondent who has not cross-appealed cannot recover a more favorable judgment from the appellate court than it had below.

Claimant is correct that the Board can reach issues raised by a responding party on *de novo* review without a formal cross-petition. *Neely v. SAIF, supra,* 43 Or App at 323. The essential prerequisite of the Board's review power is, however, that it have jurisdiction. Here, the Board acquired jurisdiction when employer filed its request for review. ORS 656.295. It lost it when employer withdrew the request. Although claimant questioned the denial of widow's benefits in her brief to the Board, the brief was filed after the statutory

period for a request for review, ORS 656.289(3),[1] and thus it could not be considered or treated as a timely cross-request. In *Neely,* the Board retained jurisdiction of the request for review and could review issues raised by the responding party. Here, when employer withdrew its request, the Board was deprived of jurisdiction and properly dismissed the case.

Affirmed.

[1] ORS 656.289(3) reads as follows:

"The 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. When one party requests a review by the board, the other party or parties shall have the remainder of the 30-day period and in no case less than 10 days in which to request board review in the same manner. The 10-day requirement may carry the period of time allowed for requests for board review beyond the 30th day. The order shall contain a statement explaining the rights of the parties under this subsection and ORS 656.295."

IN THE COURT OF APPEALS OF THE
STATE OF OREGON

In the Matter of the Compensation of
Clara J. Spurlock, Claimant.

SPURLOCK,
Petitioner,

v.

INTERNATIONAL PAPER COMPANY,
Respondent.

(WCB 85-03381; CA A43109)

Judicial Review from Workers' Compensation Board.

Argued and submitted November 6, 1987.

James L. Edmunson, Eugene, argued the cause for petitioner. With him on the brief were Malagon & Moore, Eugene, and Karen M. Werner, Eugene.

Paul Roess, Coos Bay, argued the cause for respondent. With him on the brief were Foss, Whitty & Roess, Coos Bay.

Before Warden, Presiding Judge, Joseph, Chief Judge,* and Van Hoomissen, Judge.

VAN HOOMISSEN, J.

Reversed; referee's order reinstated.

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* Joseph, C. J., *vice* Young, J., deceased.

VAN HOOMISSEN, J.

Claimant seeks review of a Workers' Compensation Board order that reversed a referee's order awarding her scheduled permanent partial disability and holding that International Paper Company (IP), a self-insured employer, is responsible for payment. We review *de novo* and reverse.

Claimant worked for IP from 1966 to 1981 as a dryer feeder. In 1977, she experienced bilateral hand and forearm numbness. Doctor Stainsby diagnosed a carpal tunnel syndrome. She filed a claim with IP, which was accepted as nondisabling. She was laid off by IP in 1981. Later, she was employed by Georgia Pacific (GP) as a dryer feeder. The numbness increased. In 1983, she left GP and took a job managing a motel. In 1983, she had bilateral carpal tunnel surgery. She filed a claim against both GP and IP; both denied her claims. IP was found to be responsible. After the surgery, her condition improved; however, she testified that she was never totally free of numbness and pain thereafter.

In 1984, claimant moved to manage another of her employer's motels. She did maid and office work. Numbness and pain in her hands increased and interfered with her work and sleep. In 1985, she filed an aggravation claim against IP, which deferred acceptance. At the hearing, she offered evidence that her condition interferred with her maid work. That

evidence was IP's first notice that she was working as a maid, and it verbally denied responsibility, contending that her present employer is responsible.

The referee found that claimant's present disability was caused by a worsening of the symptoms of the compensable carpal tunnel condition for which IP was responsible. Relying primarily on the opinion of Dr. MacCloskey, the referee found that, although claimant's motel work had aggravated the carpal tunnel condition, it had not contributed independently to the underlying pathology. Therefore, the referee held IP responsible. The Board disagreed with the referee's conclusion and reversed. Relying on the same medical evidence, it concluded that claimant's motel work had caused pathological changes and, therefore, had caused a worsening of the underlying disease. Purporting to apply the last injurious exposure rule, *see Bracke v. Baza'r,* 293 Or 239, 646 P2d

1330 (1982), the Board held that IP was not responsible for claimant's present disability.[1]

The last injurious exposure rule embodies two rules: a rule of proof and a rule of assignment of liability. *See Bracke v. Baza'r, supra,* 293 Or at 245. As a rule of proof, it relieves a claimant of the burden of proving specific causation as to any particular employment. The claimant need only prove that the disease was caused by an employment-related exposure. As a rule of assignment of liability, it places full responsibility for compensation with the last employer whose conditions last contributed to the "totality" of the claimant's disease. *See Bracke v. Baza'r, supra,* 293 Or at 248.

In *Bracke,* the claimant did not rely on the last injurious exposure rule as a rule of proof in making her *prima facie* case. Rather, she chose to prove that her disease and disability resulted from her employment with Baza'r, which was not her last employer. Baza'r asserted the rule of assignment of responsibility as a defense, arguing that the claimant's subsequent employment also could have caused her disability. The *Bracke* opinion noted that the last injurious exposure rule was designed primarily to benefit claimants. The court recognized, however, that employers have an interest in the consistent application of the rule, either as to proof or liability, so as to assure fair allocation of liability. *See Bracke v. Baza'r, supra,* 293 Or at 249-50.

The Supreme Court has ruled that, when a claimant does not rely on the rule of proof, an employer may not assert the rule of proof as a defense. *See Runft v. SAIF,* 303 Or 493, 501, 739 P2d 12 (1987); *Boise Cascade Corp v. Starbuck,* 296 Or 238, 243-45, 625 P2d 104 (1984); *Bracke v. Baza'r, supra,* 293 Or at 250 n 5. However, the rule of assignment may be asserted

[1] After the Board's order, the Supreme Court decided *Runft v. SAIF,* 303 Or 493, 739 P2d 12 (1987), where, as here, the claimant had not invoked the last injurious exposure rule, but instead chose to prove that one of her employer's working conditions was a major contributing cause of her disability. That employer's insurer sought to avoid responsibility by asserting the assignment of liability rule as a defense, although the claimant had not filed a claim against, nor had the first employer sought to join, the subsequent employer. The court held that the defense was not available to the insurer, who was aware that a responsibility issue existed and yet had not involved the later employer. Because we find that claimant's maid work did not independently contribute to her underlying disease, we do not decide whether the defense was available to IP in this case.

as a defense even when a claimant has chosen to prove actual causation, if the subsequent employment actually contributed to the worsening of an underlying disease. *See Runft v. SAIF, supra,* 303 Or at 501-2; *Bracke v. Baza'r, supra.*

In *Bracke,* the defense was unsuccessful precisely because we had found that the claimant's subsequent employment had only activated the symptoms of the pre-existing disease. The Supreme Court explained that "the onset of disability * * * is the critical event in the application of the rules [of proof and assignment]." *Bracke v. Baza'r, supra,* 293 Or at 248. Liability for the disability caused by the underlying disease is fixed when the disability arises. *Bracke v. Baza'r, supra,* 293 Or at 250. Worsening of the underlying disease is a critical event that can allow a reassignment of liability to a subsequent employer. A mere recurrence of symptoms that does not signify a worsening of the underlying disease is not an event which allows a reassignment of liability and liability remains with the employer originally held responsible. *See Boise Cascade Corp. v. Starbuck, supra,* 296 Or at 243; *Bracke v. Baza'r, supra.* In *Bracke,* the claimant had proven that disability was caused by and had arisen from her employment with Baza'r. Liability remained with Baza'r, because it failed to prove that her underlying disease had worsened since termination of her employment with Baza'r.

In this case, it has previously been determined that IP is responsible for claimant's disability.[2] To assert the last injurious exposure rule of assignment as a defense, assuming that all of the proper parties have been joined, IP must prove both that claimant's underlying disease has worsened and that her subsequent employment caused the worsening. IP has failed to show that claimant's underlying carpal tunnel syndrome has worsened. MacCloskey stated that the maid work aggravated the symptoms of the disease; however, he did not equate the worsened symptoms with the disease itself. IP has shown only that claimant's maid work was the type of work which *could* cause or aggravate carpal tunnel syndrome. That

does not support the assignment of liability to the subsequent employer.

Reversed; referee's order reinstated.

[2] Alternatively, IP argued that claimant had completely recovered from her previous carpal tunnel syndrome and that her present disability stems from a completely new occurrence of the syndrome caused by her maid work. Although there is evidence to support that theory, we are persuaded by claimant's testimony that her numbness and pain never completely abated and by MacCloskey's diagnosis that the present disability is a recurrence of the symptoms of the existing disease.

IN THE COURT OF APPEALS OF THE
STATE OF OREGON

In the Matter of the Compensation of
Antonio S. Avalos, Claimant.

AVALOS,
Petitioner,

v.

BOWYER et al,
Respondents.

(WCB 84-04390; CA A40155)

Judicial Review from Workers' Compensation Board.

Argued and submitted March 25, 1987.

Quintin B. Estell, Salem, argued the cause and filed the brief for petitioner.

Chess Trethewy, Salem, argued the cause for respondents. On the brief were Paul J. De Muniz, Gerald L. Warren, and Garrett, Seideman, Hemann, Robertson & De Muniz, P.C., Salem.

Before Richardson, Presiding Judge, and Newman and Deits, Judges.

DEITS, J.

Reversed as to determination that letter was not aggravation claim; otherwise affirmed.

DEITS, J.

Claimant seeks review of a Workers' Compensation Board order denying his claim for permanent partial disability (PPD) and holding that his letter of January 29, 1984, to insurer was not an aggravation claim. We affirm the Board's denial of PPD but reverse its conclusion that the letter was not an aggravation claim. However, we also hold that claimant is not entitled to temporary total disability benefits (TTD) retroactively to the date of the letter.

Claimant sustained a compensable injury to his left knee. He was treated the next day for knee pain by a chiropractor, who diagnosed a sprain of the medial meniscus. He was treated later by an orthopedic surgeon, who diagnosed a compression injury and prescribed physical therapy. She declared his condition stationary on December 2, 1983, and released him to work without limitation. By a determination order, claimant was awarded TTD from September 8 through December 2, 1983, but no PPD.

Claimant moved to California, and on January 29, 1984, he sent a letter to insurer stating that he could not work, because his knee hurt. Insurer responded on February 13 with the name of a California physician that it had selected to treat claimant. Insurer wrote to the physician on three occasions asking for reports on claimant. On June 4, 1984, insurer learned that the physician would not examine claimant,

because claimant had an attorney who was requesting information from him, and the doctor did not want to be involved with an attorney. On June 12, insurer sent claimant the name of another physician that it had selected. He was examined on June 26 and diagnosed as having left quadriceps atrophy and a torn lateral meniscus. A subsequent arthroscopic examination resulted in the excision of the medial shelf, followed by physical therapy.

On July 2, 1984, insurer received medical verification of claimant's inability to work. It reopened the claim on July 12 and started time loss payments on July 13, retroactive to June 26, the date of the physician's verification of his inability to work. On October 3, claimant was released for full activity without limitation. A November 20 determination order allowed TTD from June 26 through October 3, 1984, but no

PPD. Claimant returned to his California physician on February 28, 1985, complaining of pain. The physician could find nothing wrong with claimant's knee but recommended a knee sleeve and anti-inflammatory medication. Since his last medical examination, claimant has been employed to perform general maintenance, floor mopping and errands. Claimant testified that he has pain in his knee that increases when he walks more than a few blocks on rough ground, runs more than a few steps and kneels or squats.

Claimant argues that the Board erred in affirming the referee's finding that he was not a credible witness. He contends that the referee's finding was unduly based on the language barrier—claimant understood little English and communicated through an interpreter—and his reluctance to answer certain questions. We agree that a credibility finding should not be based on a claimant's language difficulties; however, the referee's credibility finding was not based solely on language difficulties. The record also reflects inconsistencies in his testimony.

Claimant also contends that the Board erred in finding that he was not entitled to PPD. However, the evidence does not establish that he sustained any permanent impairment as a result of his injury. The most recent medical report, dated February 28, 1985, indicated that claimant "is not disabled and needs no further medical treatment." Given claimant's lack of credibility as a witness and the absence of any medical evidence indicating impairment, we agree with the Board's denial of PPD.

Claimant also argues that the Board erred in concluding that his January 29, 1984, letter to insurer was not an aggravation claim and that insurer was not liable for paying TTD retroactively to the date of the letter after receiving medical verification of claimant's inability to work. An aggravation claim must put the insurer on notice that claimant seeks treatment for a worsened condition. *Krajacic v. Blazing Orchards,* 84 Or App 127, 733 P2d 113, *on reconsideration* 85 Or App 477, 737 P2d 617, *remanded for reconsideration on other grounds,* 304 Or 436, ___ P2d ___ (1987). A doctor's report may satisfy the requirement, but it is not necessary. ORS 656.273(3); *Garbutt v. SAIF,* 297 Or 148, 681 P2d 1149 (1984). We conclude that the letter was an aggravation claim.

Although he was experiencing some pain, at the time of the last award of compensation he was not limping, was medically stationary and was able to work. In the January 29 letter, he stated: "[I] am going to get a specialist for my knee, I can't work because it hurts me a lot and it's making me limp." Claimant's letter was sufficient to give notice to insurer that he sought treatment for a worsened condition related to his compensable injury.

Although we hold that claimant's letter was an aggravation claim under ORS 656.273, we affirm the Board's determination that insurer is not required to pay TTD retroactively to the date of the letter. A claim for increased disability due to aggravation is compensable for the period during which the claimant is temporarily disabled, although the first payment of compensation is not due until 14 days following receipt of medical verification. ORS 656.273(6); *Silsby v. SAIF,* 39 Or App 555, 562, 592 P2d 1074 (1979). There is no evidence, other than claimant's letter, that claimant was disabled from January 26 until June 26, 1984. His doctor did not indicate that the disabling condition had existed since the time when claimant wrote the letter, nor was there other evidence that claimant was disabled during that period. The fact that he contends that he left work is not, alone, sufficient to meet his burden of proof to show that he was, in fact, unable to work.

Claimant's reliance on *Bono v. SAIF,* 298 Or 405, 692 P2d 606 (1984), for his claim of interim compensation is misplaced. At issue in *Bono* was whether a worker who had not demonstrated absence from work was entitled to interim compensation under ORS 656.262(4). As in *Bono,* claimant here did not establish that he was absent from work during the period in question and, therefore, he was not entitled to interim compensation during that time period. Further, *Bono* did not involve an aggravation claim. ORS 656.273(6), which specifically governs the processing of aggravation claims, provides that "the first installment of compensation due under ORS 656.262(4) shall be paid no later than the 14th day after the subject employer has notice or knowledge of medically verified inability to work resulting from the worsened condition." This is in contrast to the general processing requirements of ORS 686.262(4), which provide that compensation is to be paid no later than the 14th day after the employer has

notice. In this case, claimant did not provide medical verification of his inability to work at the time of his aggravation claim; the verification was not given until July 2, 1984.

Finally, claimant contends that he is entitled to penalties and attorney fees under ORS 656.262(10) for insurer's unreasonable delay in denying or accepting his claim. Insurer received the aggravation claim on February 3, 1984, but did not reopen the claim until July 12, 1984. Given the uncertainty over whether the letter was in fact an aggravation claim, the insurer's prompt response to the letter with the name of a California physician and its three follow-up letters, we do not find insurer's delay unreasonable. We cannot award penalties, because there was "nothing then due" as required

by ORS 656.262(10). Insurer had not received medical verification and was not obligated to pay benefits at that time.

Reversed as to determination that letter was not an aggravation claim; otherwise affirmed.

IN THE COURT OF APPEALS OF THE STATE OF OREGON

In the Matter of the Compensation of Jerry E. Wojick, Claimant.

WOJICK,
Petitioner,

v.

WEYERHAEUSER COMPANY,
Respondent.

(WCB 84-02193; CA A41590)

Judicial Review from Workers' Compensation Board.

On petitioner's petition for reconsideration filed November 25, 1987. Former opinion filed September 23, 1987, 87 Or App 552, 742 P2d 1202.

James L. Edmunson, and Karen M. Werner, Eugene, for petition.

Joseph D. Robertson, Thomas E. Ewing, and Garrett, Seideman, Hemann, Robertson & De Muniz, P.C., *contra.*

Before Warden, Presiding Judge, and Joseph, Chief Judge,* and Van Hoomissen, Judge.

PER CURIAM

Reconsideration granted; former decision withdrawn; affirmed.

* Joseph, C. J., *vice* Young, J., deceased.

PER CURIAM

The Workers' Compensation Board affirmed the referee's decision that claimant's claim had not been closed prematurely. We affirmed the Board without issuing an opinion. 87 Or App 552, 742 P2d 1202 (1987). Claimant has petitioned for review, asserting that the referee and the Board improperly failed to consider medical reports which came into existence after closure on the question of whether claimant was medically stationary at the time of closure. We allow reconsideration and withdraw our former decision. ORAP 10.10. We agree that the reports should have been considered. *Scheuning v. J.R. Simplot,* 84 Or App 622, 735 P2d 1, *rev den* 303 Or 590 (1987); *Alvarez v. GAB Business Services,* 72 Or App 524, 696 P2d 1131 (1985). We have considered those reports and are not persuaded that the claim was prematurely closed.

Reconsideration granted; former decision withdrawn; affirmed.

IN THE COURT OF APPEALS OF THE
STATE OF OREGON

In the Matter of the Claimed Reimbursement to
Argonaut Insurance Co.
by the Workers' Compensation Department
of Oregon
ARGONAUT INSURANCE COMPANY et al,
Petitioners,
v.
WORKERS' COMPENSATION DEPARTMENT
OF OREGON,
Respondent.
(WCD 86-03387; CA A43764)

Judicial Review from Workers' Compensation Department.

Argued and submitted November 16, 1987.

Richard Wm. Davis, Portland, argued the cause for petitioners. With him on the brief was Davis, Bostwick, Scheminske & Lyons, Portland.

Michael C. Livingston, 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 Warden, Presiding Judge, and Joseph, Chief Judge,* and Van Hoomissen, Judge.

WARDEN, P. J.

Affirmed.

*Joseph, C. J., *vice* Young, J., deceased.

WARDEN, P. J.

Insurer seeks review of a Workers' Compensation Board referee's order[1] denying it reimbursement from the Workers' Compensation Department for temporary total disability (TTD) payments insurer made to claimant while he was participating in a vocational rehabilitation program. We affirm.

In July, 1978, claimant sustained a compensable injury to his low back. He moved to Iowa. Insurer advised the Field Services Division (FSD) of the Department[2] that claim-

[1] Insurer requested review of the referee's order by the Board. On motion of the Department, the Board dismissed insurer's request, reasoning that, inasmuch as the issue is not a matter concerning a claim, review is not subject to ORS 656.295, but rather is subject to ORS 183.310 to ORS 183.550, citing ORS 656.704(2) and OAR 436-120-250(7)and (8). The Board concluded that jurisdiction for review of the referee's decision is in the Court of Appeals. In an order withdrawing an order to show cause why judicial review should not be dismissed on the ground that review of the referee's order is by the Board, we came to the same conclusion.

[2] The Workers' Compensation *Department* administers various programs, including rehabilitation of injured workers. It is distinct from the Workers' Compensation *Board*, which adjudicates the entitlement of injured workers to benefits from their employers and their employers' insurers.

ant was requesting vocational services to be provided in Iowa. FSD notified claimant that he was not eligible for vocational services, because he was living in another state. Claimant then requested a Board hearing on the extent of his permanent disability and the question of his entitlement to out-of-state vocational retraining, without first applying to the Director of the Department for review of FSD's denial. After a July, 1983, hearing, a referee deferred any decision on the issue of the extent of disability and ordered that FSD

> "shall deem claimant entitled to a program of vocational assistance pursuant to OAR 436-61-100 and provide him with these services where claimant is currently residing in Sioux City, Iowa, without delay."

Claimant entered a motorcycle engine repair program in September, 1983. Insurer paid him TTD from September 28, 1983, the date of the referee's order on reconsideration, which for our purposes was the same as his previous order.

Insurer requested review by the Board of only those portions of the order that assessed attorney fees against it. FSD cross-requested review, alleging that claimant had failed

to exhaust his administrative remedies with regard to the issue of vocational rehabilitation. The order was vacated by the Board in August, 1984. The Board reasoned that claimant had failed to exhaust his administrative remedies under OAR 436-61-998, which required that he seek administrative review by the Director of the Department before requesting a hearing on the issue of his entitlement to out-of-state vocational training. The Board concluded that the claim was not properly before it and referred the matter to the Director. Insurer immediately stopped making TTD payments and demanded that the Department reimburse it for the TTD payments it had made from September, 1983, to August, 1984.

The Director, acting for the Department, denied insurer reimbursement, citing ORS 656.268 *(since amended by* Or Laws 1985, ch 425, § 1, and ch 600, § 8 and Or Laws 1987, ch 884, § 10), which then entitled a claimant to temporary disability compensation only when enrolled and actively engaged in an "authorized vocational rehabilitation program." It concluded that, although the referee's opinion said that the motorcycle engine repair program should be provided, it had not *ordered* FSD to provide that specific program and, therefore, the order did not constitute authorization. The Department further concluded that, because claimant did not submit the dispute to the Director for review pursuant to *former* ORS 656.728(6) *(since repealed by* Or Laws 1985, ch 600, § 2), the referee had no jurisdiction to decide the eligibility issue.

Insurer requested a hearing to contest the Department's denial of reimbursement. In February, 1987, a different referee issued an order denying reimbursement, because the program of vocational assistance in which claimant had participated in Iowa had not been authorized. He noted that claimant had not attempted to obtain authorization until after he had completed the program. Insurer petitioned for review of that opinion and order.

Insurer contends that the Director erred in refusing to reimburse it for the payments that it made while claimant was engaged in vocational training. It argues that, under the first referee's order, it was required to make the payments and

is, therefore, entitled to reimbursement. The Department contends that the program was not authorized and, because it was not, insurer is not entitled to reimbursement.

Under *former* ORS 656.268(1), applicable to this case, time loss benefits were to continue after a worker became medically stationary

> "if the worker is enrolled and actively engaged in an authorized program of vocational rehabilitation that has been provided according to rules adopted pursuant to ORS 656.728 * * *."

Former ORS 656.728(3) provided in part:

> "The director shall by rule provide for reimbursement to the insurer * * * from the Rehabilitation Reserve any sums paid as temporary disability compensation after the date the worker is determined to be medically stationary until a program of rehabilitation has been terminated as provided by ORS 656.268."

Former ORS 656.728(6), provided:

> "If a worker is dissatisfied with a decision by the department or by an insurer or self-insured employer regarding the eligibility of the worker to receive vocational assistance or regarding the nature or quality of the assistance the worker is receiving, the worker must first apply to the director for review of the decision. Decisions of the director may be reviewed pursuant to ORS 656.283."

Former ORS 656.283 *(since amended by* Or Laws 1985, ch 600, § 9, and Or Laws 1987, ch 884, § 11) provided, in part:

> "Subject to ORS 656.319, any party or the director may at any time request a hearing on any question concerning a claim. However, decisions of the director regarding participation in, but not eligibility for, an authorized vocational rehabilitation program may be modified only if the decision of the director:
>
> "(a) Violates a statute or rule;
>
> "(b) Exceeds the statutory authority of the agency;
>
> "(c) Was made upon unlawful procedure; or
>
> "(d) Was characterized by abuse of discretion or clearly unwarranted exercise of discretion."

The Department argues that, because claimant failed to apply to the Director for review of the FDS's denial as

required by *former* ORS 656.728(6), the first referee had no Department decision before him for determination and, therefore, no jurisdiction to determine the merits of the question presented. We agree that the referee had no authority to require the FSD to provide claimant the particular program of vocational assistance that he did. Although *former* ORS 656.283 provided that any party could request a hearing at any time concerning a claim, the statute required that there be a director's decision before there could be a hearing on issues of

participation in a program of vocational rehabilitation program as provided by *former* ORS 656.728(6). *See also* OAR 436-61-988. The regulations promulgated by the director pursuant to *former* ORS 656.728(3) make it clear that reimbursement to the insurer in this case is contingent on authorization for the particular program by the Department. *See former* OAR 436-61-400 and *former* OAR 436-61-430(5). The first referee, therefore, had no authority to determine claimant's eligibility for the out-of-state services. Because his order could not have constituted "authorization," insurer is not entitled to reimbursement of TTD payments.

Affirmed.

IN THE COURT OF APPEALS OF THE STATE OF OREGON

In the Matter of the Compensation of Margaret F. Blakely, Claimant.

BLAKELY,
Petitioner,

v.

SAIF CORPORATION et al,
Respondents.

(WCB 84-02190; CA A40273)

Judicial Review from Workers' Compensation Board.

Argued and submitted April 20, 1987.

David C. Force, Eugene, argued the cause and filed the brief for petitioner.

Darrell E. Bewley, Assistant Attorney General, Salem, argued the cause for respondent SAIF Corporation. With him on the brief were Dave Frohnmayer, Attorney General, and Virginia L. Linder, Solicitor General, Salem.

Jerry K. Brown, McMinnville, argued the cause for respondents Medford School District and Western Employers' Insurance Co. With him on the brief was Cummins, Cummins, Brown, Goodman & Fish, P.C., McMinnville.

Before Richardson, Presiding Judge, and Newman and Deits, Judges.

DEITS, J.

Affirmed.

DEITS, J.

Claimant seeks review of a Workers' Compensation Board order affirming the referee and holding that claimant failed to prove that her bilateral carpal tunnel syndrome was compensable. On *de novo* review, we affirm.

Between 1974 and 1980, claimant worked as a custodian for the Medford School District (District). Her duties included wiping walls and windows, waxing floors and doing

various other cleaning activities.[1] In 1980, she was promoted to Head Custodian, a position which required maintenance work, but less cleaning. In September, 1981, she sustained a compensable injury to her lower back.[2] She returned to work in a part-time position in the spring of 1982, and to a full-time position in July, 1982. Following her return to work, her duties were basically the same as when she was only a custodian. Her activities outside work did not require a similar degree of hand use. Near the end of 1982, she began to experience intermittent numbness and tingling in her hands, worse on the right, which progressed and eventually became painful. She had not experienced any such symptoms previously.

In March, 1983, claimant complained about the symptoms to several doctors, all of whom were treating her for her 1981 back injury. Dr. Campagna noted that the hand symptoms were worse after a day of work and while driving. Her complaints persisted, and Campagna performed motor nerve conduction studies in December, 1983. He diagnosed bilateral carpal tunnel syndrome secondary to claimant's occupation. He performed right and left carpal tunnel decompressions in January and February, 1984. Claimant filed an occupational disease claim with Western Employers, which denied the claim. SAIF was joined as a necessary party by the referee at a hearing convened to contest Western Employers' denial.

Claimant argues that her carpal tunnel syndrome arose out of her employment with District during the time when Western Employers was the responsible carrier. In order to establish that the syndrome is compensable, she must prove by a preponderance of the evidence that her condition is an occupational disease. ORS 656.802(1)(a); *Clark v. Erdman Meat Packing,* 88 Or App 1, 744 P2d 255 (1987). To do so, she must show that her work activities were the major contributing cause of either the onset or the worsening of her underlying condition. *Dethlefs v. Hyster Co.,* 295 Or 298, 667 P2d 487 (1983); *Weller v. Union Carbide,* 288 Or 27, 602 P2d 259 (1980).

The medical evidence is conflicting. All four of the doctors who offered opinions in this case diagnosed the condition as carpal tunnel syndrome. There was no consensus, however, regarding the cause of claimant's condition. Campagna, her treating physician and a neurosurgeon, concluded that her "work activities as a custodian were the major contributing cause of her bilateral upper extremity disability." However, there is no evidence that Campagna was aware of the details of claimant's duties as a custodian or of her non-work activities. Further, the persuasiveness of his conclusion is reduced,

[1] The referee described claimant's duties as:

"wiping walls and windows, about 45 minutes a day; stripping and waxing floors; cleaning under chairs and desk as she tipped or moved them with the left hand while she held a long handled mop or broom with her dominant right hand; buffing floors with a buffer that she gripped with both hands; lifting bookcases, desks and sewing machines while cleaning them and the area around them; pushing 'heavy carts' up ramps."

[2] At that time, SAIF was the responsible insurance carrier for District. Western Employers assumed compensation coverage for District on July 22, 1982.

because he did not offer any explanation as to how her duties could have caused her condition.[3] *See Moe v. Ceiling Systems*, 44 Or App 429, 606 P2d 644 (1980).

The testimony of Dr. Gell, a rheumatologist, who examined claimant several months after her surgery, also is not persuasive. He testified that her work activities could have led to clinical signs of carpal tunnel syndrome. However, although he found that her work was a factor in causing her

condition, he stated that he did not know if her work activities were the major contributing cause of her condition.

The reports of a second neurologist, Dr. Rosenbaum, were also admitted into evidence. In the first report, written several months after claimant's surgery, Rosenbaum stated that, on the basis of claimant's history, the "medical probability" is that claimant had a work-related carpal tunnel syndrome arising from her occupation, rather than from a specific injury. However, in a second report, written nearly a year later, he stated that he could not decide what had caused the syndrome. He indicated that she "might have had" a normal median nerve until 1982, and her return to work possibly related to a change in duties, "might have" caused the development of her condition or, in the alternative, she "might have had" an underlying abnormal asymptomatic median nerve of unknown duration, in which case her work activities would not have caused the underlying abnormality, but may have resulted in the symptoms of pain, tingling and numbness.

Dr. Nathan, an orthopedic surgeon who specializes in hand surgery and who had examined claimant, testified that, in his opinion, her work activities were not the major contributing cause of her carpal tunnel syndrome. His rationale, based on his studies of this disease, was that the disease is present in a large number of people and, as part of the natural aging process, eventually becomes symptomatic, regardless of the person's occupation. He concluded that, because of claimant's age and sex, she fell into a high risk group. He further noted that, if her work was the cause, he would have expected symptoms to have developed shortly after her employment started, rather than seven years later.

We conclude that claimant has not sustained her burden of establishing a causal connection between her employment and the onset of her condition. Although we express no view about Nathan's underlying theories, his entire testimony, considered with the conclusory or equivocal opinions of the other doctors, persuades us that claimant did not meet her burden of showing that her work activities were the major contributing cause of her condition.

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[3] Claimant appears to argue that, under ORS 656.310(2), Campagna's written report stating that her condition was causally related to her work, established a *prima facie* case for compensability. She misconstrues the statute. ORS 656.310(2) states that

> "[t]he contents of medical, surgical and hospital reports presented by claimants for compensation shall constitute *prima facie* evidence *as to the matter contained therein* * * *." (Emphasis supplied.)

Although the statute provides that a doctor's testimony is unnecessary if a report is provided, the statute does not free a claimant from the burden of proving compensability by a preponderance of the evidence. Claimant also requests that we take judicial notice of the fact that it would have been extremely expensive for claimant to secure Campagna's live testimony in order to further explain his conclusions. That is not a proper fact for judicial notice. *See* OEC 201(b).

Claimant also failed to prove any worsening of an underlying carpal tunnel condition. Although Rosenbaum suggested that she may have had an underlying condition

before her return to work in 1982 and that work exacerbated her symptoms, he did not discuss whether the work resulted in a worsening of the condition. *See Weller v. Union Carbide, supra.*

Finally, claimant contends that her carpal tunnel syndrome is compensable as an aggravation of her 1981 compensable injury. She argues that she would not have developed the syndrome but for the fact that her 1981 injury resulted in her extended absence from work and her inability to resume her position as Head Custodian. There is no persuasive evidence to support this argument.

Affirmed.

IN THE COURT OF APPEALS OF THE STATE OF OREGON

In the Matter of the Compensation of Robert F. Sykes, Claimant.

SYKES,
Petitioner,

v.

WEYERHAEUSER COMPANY,
Respondent.

(WCB 85-04503; CA A42587)

Judicial Review from Workers' Compensation Board.

Argued and submitted August 31, 1987.

Karen M. Werner, Eugene, argued the cause for petitioner. With her on the brief were James L. Edmunson and Malagon & Moore, Eugene.

Allan M. Muir, Portland, argued the cause for respondent. With him on the brief were William H. Replogle and Schwabe, Williamson & Wyatt, Portland.

Before Richardson, Presiding Judge, and Newman and Deits, Judges.

RICHARDSON, P. J.

Reversed; referee's order reinstated.

RICHARDSON, P. J.

Claimant seeks review of a Workers' Compensation Board order holding that he is not entitled to temporary total disability, because he has "effectively retired." We reverse.

Claimant, a 54-year-old lumber worker, suffered a series of heart attacks and underwent quadruple bypass sur-

gery between 1972 and 1983. In early 1983, he returned to light duty in a lumber mill, first as a "clipper spotter" and then as a "clipper operator." The latter position was particularly well suited to his physical limitations, because it allowed him to sit down and required only that he activate a button when appropriate. In February, 1985, the mill was placed on a work week consisting of four ten-hour days. A short time later, the jobs of clipper operator and clipper spotter were consolidated. Claimant experienced increasing difficulties performing those consolidated duties. He wrote a note to his employer requesting lighter work. At approximately the same time, the production of the mill was substantially reduced and claimant was laid off.

When the mill later increased production, claimant sought reemployment in the mill's general labor pool. Employer, however, did not have a position that it believed would fit the limitations set by claimant's physician. Claimant became despondent over his physical condition and employment prospects and began treatment with a psychiatrist. He applied for unemployment compensation. Three months later, he filed a workers' compensation claim, seeking temporary total disability for aggravation of his psychological and medical condition. Employer denied the claim.

The referee found no aggravation of claimant's physical condition but granted temporary total disability on the basis of aggravation of his psychological condition. The referee specifically found that claimant had not voluntarily retired. On appeal, the Board reversed, finding that claimant had "effectively retired" because of his physical condition some months before the filing of his aggravation claim.[1]

Employes who withdraw from the work force are not entitled to temporary total disability benefits. *Cutright v. Weyerhaeuser Co.*, 299 Or 290, 702 P2d 403 (1985). The issue here is factual. The Board cited our decision in *Karr v. SAIF*, 79 Or App 250, 719 P2d 35, *rev den* 301 Or 765 (1986), as the basis for its conclusion that claimant had retired, although perhaps involuntarily. *Karr* is factually distinguishable. There, the claimant had in fact retired and showed that decision by applying for Social Security and employment-related retirement benefits. He claimed that the decision to retire was not voluntary but was necessitated by his physical condition.

[1] The Board's opinion states, in relevant part:

"Claimant suffers from the compensable physical and psychological effects of multiple myocardial infarctions. We find that as a result of those effects claimant effectively retired from the workforce several months before his treating psychiatrist found him not medically stationary from a psychiatric standpoint on August 27, 1985. In his Opinion and Order dated April 23, 1986, the Referee awarded temporary total disability compensation beginning on the date claimant was declared not medically stationary. The employer requested reconsideration, asserting that under *Cutright v. Weyerhaeuser*, 299 Or 290 (1985), a claimant who has voluntarily retired from the workforce is not entitled to receive temporary disability compensation. In his Order on Reconsideration dated May 15, 1986, the Referee adhered to his prior order, finding that claimant had not *voluntarily* left the workforce, thereby implying that the effects of claimant's compensable conditions had necessitated his leaving work.

"One day before the Referee's Order on Reconsideration was published, the Court of Appeals decided *Karr v. SAIF*, 79 Or App 250 (1986), wherein it held that a retired claimant is not entitled to receive temporary total disability payments, regardless of whether he retires voluntarily or involuntarily. We are bound by the court's decision. The present claimant, who is retired, is not entitled to temporary total disability."

We concluded that a worker who withdraws from the work force, even involuntarily, is foreclosed from temporary total disability benefits.

Claimant has not withdrawn from the work force.[2] He has indicated a reluctance to return to work because of his physical limitations but has expressed a willingness to accept employment within his limitations. There may be questions about his motivation to return to work, but he has not voluntarily or involuntarily withdrawn from the work force.

Reversed; referee's order reinstated.

[2] Claimant received unemployment compensation after he was laid off. *See Wells v. Pete Walker's Auto Body*, 86 Or App 739, 740 P2d 245, *rev den* 304 Or 406 (1987).

IN THE COURT OF APPEALS OF THE STATE OF OREGON

In the Matter of the Compensation of Donald E. Geddes, Claimant.

WILSON et al,
Petitioners,

v.

GEDDES et al,
Respondents.

(WCB 83-11452; WCB 83-12221; WCB 83-12222; WCB 83-00025; WCB 85-21111; WCB 85-02112; CA A42025)

Judicial Review from Workers' Compensation Board.

Argued and submitted November 6, 1987.

Craig A. Staples, Portland, argued the cause for petitioners. With him on the brief was Roberts, Reinisch & Klor, Portland.

John E. Uffleman, Hillsboro, argued the cause and filed the brief for respondent Donald E. Geddes.

Lin Zimmerman, Portland, argued the cause for respondents Kenny Morgan/Kenny's IGA and EBI Companies. On the brief was Randy G. Rice, Portland.

Allan M. Muir, Portland, argued the cause for respondents Armintrout/QFM Thriftway and Fremont Indemnity/U.G. Insurance. With him on the brief were Roger A. Luedtke and Schwabe, Williamson & Wyatt, Portland.

Before Warden, Presiding Judge, and Joseph, Chief Judge,* and Van Hoomissen, Judge.

WARDEN, P. J.

Reversed as to award to claimant of attorney fees for responsibility hearing; otherwise affirmed.

* Joseph, C. J., *vice* Young, J., deceased.

WARDEN, P. J.

Petitioners seek review of a Workers' Compensation Board order that found Wilson's IGA responsible for claimant's disability and awarded attorney fees to claimant. On *de novo* review, we agree with the Board that Wilson's IGA is responsible, because claimant's work there independently contributed to his disability.[1]

Petitioners also challenge the award of attorney fees to claimant on the responsibility issue, contending that claimant is only a nominal party and not entitled to attorney fees for the hearing which was conducted under ORS 656.307.[2] Although attorney fees are ordinarily not recoverable by a claimant in a responsibility proceeding, *Petshow v. Farm Bureau Ins. Co.*, 76 Or App 563, 569, 710 P2d 781 (1985), *rev den* 300 Or 722 (1986), he may be entitled to attorney fees if he is "required to appear and participate to avoid a loss of compensation." *Anfora v. Liberty Communications,* 88 Or App 30, 33, 744 P2d 265 (1987). Here, all three insurers conceded the compensability of the claim, and claimant's right to compensation was not in jeopardy.[3] Furthermore, claimant's attorney participated with respect to the responsibility issue, at the request of counsel for the insurers, only because the factual background to be elicited through claimant's answers to his attorney's questions would be identical to that required for claimant's permanent partial disability claim, which was being considered in the same proceeding.[4] Claimant's attorney

therefore did not participate meaningfully with respect to the responsibility issue. Claimant is not entitled to attorney fees for the responsibility proceeding.

Reversed as to award to claimant of attorney fees for responsibility hearing; otherwise affirmed.

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[1] Detailing the facts of this case would not aid the Board or the Bar. *See Hoag v. Duraflake*, 37 Or App 103, 585 P2d 1149, *rev den* 284 Or 521 (1978).

[2] Hearings are held under ORS 656.307 when responsibility, but not compensability, for a claimant's disability is at issue. Or Laws 1987, ch 713, § 5, amended ORS 656.307(5) to provide, in relevant part:

> "If the claimant appears at [a hearing held under ORS 656.307] and actively and meaningfully participates through an attorney, the arbitrator may require that a reasonable fee for the claimant's attorney be paid by the employer or insurer determined by the arbitrator to be the party responsible for paying the claim."

The amendment became effective January 1, 1988, and is not applicable here.

[3] Claimant's contention that Wilson's IGA did not admit compensability is not supported by the record. Wilson's IGA consistently asserted that claimant's disability resulted from an aggravation of a compensable injury that had occurred four years earlier at QFM Thriftway.

[4] Counsel for the insurers acquiesced in the participation of claimant's attorney after being expressly warned by the referee that such participation would be considered in awarding attorney fees. Their acquiescence, however, cannot be construed as a stipulation that claimant was entitled to attorney fees. *Cf. Evans v. Rookard*, 85 Or App 213, 735 P2d 662 (1987) (enforcing insurer's stipulation that it would pay attorney fees to claimant if claimant prevailed against it in responsibility hearing).

IN THE COURT OF APPEALS OF THE
STATE OF OREGON

In the Matter of the Compensation of
Richard A. Moore, Claimant.

EBI COMPANIES et al,
Petitioners,

v.

MOORE,
Respondent.

(WCB 86-00561; CA A44104)

Judicial Review from Workers' Compensation Board.

Argued and submitted January 15, 1988.

Richard Wm. Davis, Portland, argued the cause for petitioners. With him on the brief were Alley W. Lyons and Davis, Bostwick, Scheminske & Lyons, Portland.

Charles D. Maier, Salem, argued the cause for respondent. With him on the brief was Gatti, Gatti, Maier, Smith and Associates, Salem.

Before Buttler, Presiding Judge, and Warren and Rossman, Judges.

WARREN, J.

Reversed with instruction to dismiss proceeding.

WARREN, J.

In this workers' compensation case, claimant's employer and its insurer seek review of a Workers' Compensation Board order affirming the referee's determination that insurer violated a disputed claim settlement agreement. Insurer contends that, because claimant is not a real party in interest, his request could not invoke the referee's and Board's jurisdiction. It further argues that, even if the Board had jurisdiction, it erred in holding insurer in violation of the settlement.

The referee made these findings:

> "Claimant was compensably injured October 14, 1984. Apparently, the condition involved was the upper back area or neck area. The claim was accepted.
>
> "Claimant filed a claim for a disabling psychiatric condition, alleging the condition was compensable in relationship to the October 14, 1984, industrial injury. EBI resolved the issue of compensability of the psychiatric condition under a Disputed Claims Settlement Agreement of October 3, 1985. The agreement, in part, provided that EBI Companies would 'resolve outstanding medical billings of Dr. Albert Sheff and hold claimant harmless from any such bills which are understood to total, at this time, the approximate sum of $1,358.10.' EBI Companies paid the sum of $679.05 only. Claimant understood, at the time of the execution of the agreement, that the sum of $1,358.10 would be paid * * *."

The Board affirmed the referee's conclusion that claimant's request to enforce the settlement agreement was a claim over which he had jurisdiction and ordered insurer to pay claimant's medical bills in full.

ORS 656.289(4), under which the insurer paid, provides:

> "Notwithstanding ORS 656.236, in any case where there is a bona fide dispute over compensability of a claim, the parties may, with the approval of a referee, the board or the court, by agreement make such disposition of the claim as is considered reasonable. If disposition of a claim referred to in ORS 656.313(3) is made pursuant to this subsection and the insurer or self-insured employer and the affected medical service and health insurance providers are unable to agree on the issues of liability or the amount of reimbursement to the medical service and health insurance providers, and the amount in dispute

> is $2,000 or more, those matters shall be settled among the parties by arbitration in proceedings conducted independent of the provisions of this chapter. If the amount in dispute is less than $2,000, the insurer or self-insured employer shall pay to the medical service and health insurance provider one-half the disputed amount. As used in this subsection 'health insurance' has the meaning for that term provided in ORS 731.162."

We agree with claimant that the referee and Board had jurisdiction to enforce the agreement but conclude that the insurer has not breached it. Because this was a disputed claim settlement and the amount in issue was less than $2,000, the insurer was entitled to "resolve" the outstanding medical bill of Sheff as it did by paying one-half of the bill. Claimant's unilateral understanding that the bill would be paid in full was not part of the contract.

In the settlement, insurer promised to "hold [claimant] harmless from any such bills." The effect of the agreement was to provide claimant with indemnity against claims made by medical services providers. It follows that claimant may enforce the agreement only if insurer ever fails to indemnify him in the event that he is required to defend against or pay the balance of the medical bill.

Reversed with instruction to dismiss the proceeding.

IN THE COURT OF APPEALS OF THE
STATE OF OREGON

In the Matter of the Compensation of
Abraham W. Ring, Claimant.

RING,
Petitioner,

v.

PAPER DISTRIBUTION SERVICES, INC.,
Respondent.

(85-03639; CA A41872)

Judicial Review from Workers' Compensation Board.

Argued and submitted November 13, 1987.

Dennis O'Malley, Portland, argued the cause and filed the brief for petitioner.

Patric J. Doherty, Portland, argued the cause for respondent. With him on the brief were Karli L. Olson and Rankin, VavRosky, Doherty, MacColl & Mersereau, Portland.

Before Buttler, Presiding Judge, and Warren and Rossman, Judges.

ROSSMAN, J.

Reversed and remanded with instructions to reinstate proceeding.

ROSSMAN, J.

Claimant filed a back injury claim. Employer denied the claim on the grounds that it was not timely filed or, in the alternative, that the injury was not related to claimant's employment. In the months following the denial, claimant either did not receive notice of or refused to cooperate with employer's attempts to have him submit to an independent medical examination. The referee apparently found that claimant had failed to cooperate and, without reaching the merits of the denial, dismissed the proceeding. The Board affirmed.

ORS 656.325(1) provides:

> "Any worker entitled to receive compensation under ORS 656.001 to ORS 656.794 is required, if requested by the director, the insurer or self insured employer, to submit to a medical examination at a time and from time to time at a place reasonably convenient for the worker and as may be provided by the rules of the director. * * * If the worker refuses to submit to any such examination, or obstructs the same, the rights of the worker to compensation shall be suspended with the consent of the director until the examination has taken place, and no compensation shall be payable during or for account of such period."

The procedure for obtaining approval for the sanction pro-

vided by ORS 656.325(1) is set out in OAR 436-60-090, which provides, *inter alia,* for notice to the claimant and an opportunity to respond and to request a hearing.

This claim was in denied status when claimant allegedly refused to cooperate. Employer was therefore not paying compensation and, thus, the sanctions permitted by ORS 656.325(1) would not have been of direct benefit to employer. Although we agree that a claimant should not be allowed to reap the benefits of the workers' compensation system without the modest level of cooperation that the statute requires, there is no authority for the dismissal of a proceeding in these circumstances. It may be that claimant's refusal to cooperate caused an unjustified delay in prosecution which would warrant dismissal of the claim pursuant to OAR 438-06-085. That is for the referee to determine in the first instance.

Reversed and remanded with instructions to reinstate the proceeding.

IN THE COURT OF APPEALS OF THE STATE OF OREGON

In the Matter of the Compensation of Merlyn G. Johnsen, Claimant.

JOHNSEN,
Petitioner,

v.

HAMILTON ELECTRIC et al,
Respondents.

(WCB 83-06970; CA A42318)

Judicial Review from Workers' Compensation Board.

Argued and submitted November 2, 1987. Petition dismissed December 23, 1987. 89 Or App 88, 746 P2d 1169.

On petitioner's petition for reconsideration filed December 30, 1987.

David C. Force, Eugene, for petition.

Before Buttler, Presiding Judge, and Warren and Rossman, Judges.

ROSSMAN, J.

Petition for reconsideration granted; former opinion withdrawn; affirmed.

ROSSMAN, J.

In this worker's compensation case, claimant petitions for review of our decision dismissing his petition on the ground that Argonaut had not been served with a copy of the

petition for review. 89 Or App 88, 746 P2d 1169 (1988). We treat the petition for review as a petition for reconsideration. ORAP 10.10. We conclude that service of the petition on Argonaut's attorney was sufficient under ORS 656.298(3). We withdraw our former opinion and address the merits of the case.

Claimant seeks a determination that he suffers from a compensable asbestos-related lung condition and that annual diagnostic chest x-rays are compensable. From 1956 to 1967, claimant was exposed to asbestos dust nine times while working for employer as an electrician. He began having regular physicals in 1973. In April, 1979, Dr. Williams, his family physician, noticed some abnormalities in claimant's chest x-ray. Because claimant had been suffering several months from a cough and, because of his history of exposure to asbestos, Williams referred claimant to Dr. Turner, a pulmonary specialist. Turner noted, in May, 1979, that claimant's past chest x-rays indicated that, since 1976, his abnormal lung marks had increased. His "impression" was "asymptomatic interstitial lung disease, R/O asbestosis." Claimant had no asbestos fibers in his sputum. Turner thought that claimant's history was consistent with asbestosis and recommended that he have a yearly chest x-ray, because "the incidence of lung tumors is increased in patients exposed to asbestos." Williams at one point interpreted Turner's report to mean that pleural shadows on claimant's lung "might represent asbestosis." In a later report to claimant, he referred to the "former diagnosis of asbestosis," and he reported to SAIF in 1984 that claimant had a "persistent chest x-ray finding which is probably due to asbestosis."

Dr. Hansen, a pulmonary specialist and SAIF's consulting physician, examined claimant and his medical records. He stated that, although x-ray findings in claimant's left lower lung are consistent with asbestos exposure, they are also consistent with other post-inflammatory etiology. Hansen noted that the pleural thickening of the left lower lung had stabilized since 1981. He stated that lung volume appeared essentially

unaffected and that there was nothing to suggest a diffuse interstitial process. Because he concluded that there was no evidence of diffuse or bilateral pulmonary fibrosis, he stated that he could not make a diagnosis of asbestosis.

On *de novo* review, we are persuaded by the medical evidence indicating that claimant does not have asbestosis. Williams appeared to have relied on Turner's 1979 report, which, despite Williams' assumption, did not diagnose asbestosis. Hansen, who examined claimant in September, 1986, explained persuasively that the marks on claimant's lung do not unequivocally indicate asbestosis or an interstitial process. We find that there has been no diagnosis of asbestosis and that, although the "findings" on claimant's lung are consistent with a pre-asbestosis condition, he does not have asbestosis. Assuming that what the findings do amount to is related to claimant's employment, however, the question remains whether, in the absence of disability, symptoms or a need for treatment, claimant suffers from an "occupational disease" so as to enable him to recover benefits for reasonable and necessary medical services.

An occupational disease is defined as "any disease or infection which arises out of and in the scope of the employment." ORS 656.802. Diseases are considered injuries under the workers' compensation law, except as otherwise provided in ORS 656.802 to ORS 656.824. ORS 656.804. Claimant seizes upon that to suggest that the definition of "compensable injury" in ORS 656.005(8) is relevant in determining whether there can be a non-disabling occupational disease. That analysis is supported by *Weller v. Union Carbide,* 288 Or 27, 30-31, 36, 602 P2d 259 (1979), where the Supreme Court held that ORS 656.005(8) is pertinent in determining whether workers' compensation benefits are available for a pre-existing condition. ORS 656.005(8)(a) defines "compensable injury," in part, as an accidental injury requiring medical services. A "non-disabling compensable injury" is any injury "which requires medical services only." ORS 656.005(8)(c). We conclude, in view of the Supreme Court's opinion indicating that those definitions are pertinent with regard to occupational diseases, that it is possible to have a non-disabling occupational disease, *i.e.,* one that requires medical services only. However, the definitions contained in ORS 656.005(8) still require that there in fact be an injury, or in this case, a

disease. Here, the condition of claimant's lung is not asbestosis or any other disease. Accordingly, even if the condition is related to his employment, it is not one for which he is entitled to compensation.[1]

Petition for reconsideration granted; former opinion withdrawn; affirmed.

[1] We note that an employer may pay for diagnostic procedures without accepting a claim or assuming responsibility for the condition that may ultimately be diagnosed. ORS 656.262(9).

IN THE SUPREME COURT OF THE
STATE OF OREGON

In the Matter of the Compensation of
Dawn White, Claimant.

NORTH CLACKAMAS SCHOOL DIST.,
Respondent on Review,

v.

WHITE,
Petitioner on Review.

(WCB 83-09151; CA A36411; SC S34192)

In Banc

On review from the Court of Appeals.*

Argued and submitted October 7, 1987.

Donald E. Beer, of Galton, Popick & Scott, P.C., Portland, argued the cause for petitioner on review. Alan M. Scott, Portland, filed the petition for review.

Jerald P. Keene, of Roberts, Reinisch & Klor, P.C., Portland, argued the cause and filed a response to the petition for respondent on review.

PETERSON, C. J.

The decision of the Court of Appeals is reversed. The case is remanded to the Court of Appeals to decide, as a matter of fact, whether the claimant's hip condition has worsened and whether insurer's partial denial of the need for further medical care and treatment was proper.

* Judicial review from an order of the Workers' Compensation Board. 85 Or App 560, 737 P2d 649 (1987).

PETERSON, C. J.

The question in this workers' compensation case is whether the claimant's assertion of a medical expenses claim and an aggravation claim are precluded by an earlier ruling of the Workers' Compensation Board (Board). The Court of Appeals held that the claims were precluded. *North Clackamas School Dist. v. White*, 85 Or App 560, 737 P2d 649 (1987). We hold that the claims are not precluded.

This case concerns rules commonly referred to as the rules of res judicata, long established in Oregon common law jurisprudence. The term "res judicata" has been used to refer to the preclusive effect on the *claim*. *See, e.g., Taylor v. Baker*, 279 Or 139, 144, 566 P2d 884 (1977); *Dean v. Exotic Veneers, Inc.*, 271 Or 188, 194, 531 P2d 266 (1975). The term "collateral estoppel" referred to the preclusive effect on *issues*. *See, e.g., Jones v. Flannigan*, 270 Or 121, 124, 526 P2d 543 (1974); *Gaul v. Tourtellotte*, 260 Or 14, 17, 488 P2d 416 (1971). The editors of the Restatement, in Restatement (Second) of Judgments (1980), now refer to the preclusive effect on the claim as "claim preclusion" and the preclusive effect on an issue as "issue preclusion." *See* Restatement (Second) of Judgments, Introduction at 1-5 (1980). Those terms better describe the rules for which they are shorthand. In this opinion we will use

those terms as well. As do the editors, we will refer to the law of res judicata or to the rules of res judicata. These terms include both issue preclusion and claim preclusion.

In *State Farm Fire & Cas. v. Reuter*, 299 Or 155, 158, 700 P2d 236 (1985), we described the common-law doctrine as follows:

> "If a person has had a full and fair opportunity to litigate a claim to final judgment, most courts (including this one) hold that the decision on a particular issue or determinative fact is determinative in a subsequent action between the parties on the same claim (direct estoppel). *See, e.g., Waxwing Cedar Products v. Koennecke*, 278 Or 603, 610, 564 P2d 1061, 1064-65 (1977); *Bahler v. Fletcher*, 257 Or 1, 4, 474 P2d 329, 331 (1970). The judgment generally is conclusive as well in a different action between parties as to issues actually litigated and determined in the prior action if their determination was essential to the judgment (collateral estoppel)."

Application of res judicata rules prevents harassment by successive proceedings and promotes economy of resources in the

adjudicatory process. *Dean v. Exotic Veneers, Inc., supra*, 271 Or at 192.

ORS 43.130[1] makes court judgments, decrees and final orders conclusive upon parties and their successors in interest. The statute is not applicable here because the statute requires the first proceeding to be "before a court or judge." The first proceeding ended at the Board, which is not a "court or judge."

This is the first time that we have been asked to determine whether res judicata is applicable where an administrative agency is faced with a second proceeding involving the same parties and, arguably, the same claim.[2] The Oregon

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[1] ORS 43.130 provides:

> "The effect of a judgment, decree or final order in an action, suit or proceeding before a court or judge of this state or of the United States, having jurisdiction is as follows:
>
> "(1) * * * * *
>
> "(2) In other cases, the judgment, decree or order is, in respect to the matter directly determined, conclusive between the parties, their representatives and their successors in interest by title subsequent to the commencement of the action, suit or proceeding, litigating for the same thing, under the same title and in the same capacity."

[2] In *State ex rel Huntington v. Sulmonetti*, 276 Or 967, 970, 557 P2d 641 (1976), we assumed that the doctrine was applicable in a workers' compensation case in which the issue involved the timeliness of filing a claim. *Bandy v. Norris, Beggs & Simpson*, 222 Or 1, 342 P2d 839, 351 P2d 445 (1959), held that a worker who applied for and received benefits under the workers' compensation law was precluded from maintaining an action for damages against his employer under the Employers' Liability Law. Justice Lusk, concurring, stated:

> "But the question here is as to the effect of the award which the plaintiff sought and obtained from the Commission. While it is not *res judicata* in the technical sense, for the defendant was not a party to the proceeding before the Commission, it does, as I view it, have the force of a judgment for the purpose of the present case. It establishes the fact that plaintiff was the employee of an employer under the Workmen's Compensation Law, who was awarded compensation for an injury."

222 Or at 23-24.

In *State v. Ratliff*, 304 Or 254, 258, 744 P2d 247 (1987), the issue was "whether the doctrine applies when a defendant in a criminal case seeks to estop the state from litigating an issue based upon the decision of a hearings officer in [a Motor Vehicles Division] administrative proceeding." We stated:

> "It is possible that some [administrative proceedings] may provide sufficiently formal and comprehensive procedures so that a decision in an administrative proceeding may have collateral estoppel effect in a subsequent judicial proceeding. However, the proceeding in this case is inadequate to justify the use of collateral estoppel."

Id.

Court of Appeals has recognized the doctrine in workers' compensation cases. *See, e.g., Million v. State Acc. Ins. Fund,* 45 Or App 1097, 610 P2d 285 (1980); *Reed v. Del Chem. Corp.,* 40 Or App 599, 595 P2d 1291 (1979); *Bowser v. Evans Prods. Co.,* 17 Or App 542, 522 P2d 1405 (1974).[3]

Although judge-made res judicata rules may not be applicable to all administrative proceedings, we should apply them where they facilitate prompt, orderly and fair problem resolution. Professor Davis states this view:

> "As a matter of principle, it is completely clear that the reasons behind the doctrine of res judicata as developed in the court system are fully applicable to *some* administrative proceedings. The reasons against a second litigation between the same parties of the same claims or issues are precisely the same for some administrative determinations as they are for most judicial determinations. The sound view is therefore to use the doctrine of res judicata when the reasons for it are present in full force, to modify it when modification is needed, and to reject it when the reasons against it outweigh those in its favor."

2 Davis, Administrative Law Treatise 548, § 18.02 (1958) (footnote omitted; emphasis in original).

The American Law Institute agrees. Section 83(1) of Restatement (Second) of Judgments states:

> "(1) Except as stated in Subsections (2), (3), and (4), a valid and final adjudicative determination by an administrative tribunal has the same effects [as in civil cases] under the rules of res judicata, subject to the same exceptions and qualifications, as a judgment of a court."

We see no reason why the rules of res judicata should not apply in this case. The same quality of proceedings and opportunity to litigate is present in both proceedings. If the incentive to litigate the question is substantially the same, the procedural requisites for application of the issue preclusion rule would appear to exist. *See* Restatement (Second) of Judgments, Introductory Note to Ch 6 at 265 (1980). The forum—the Board—is the same in both cases. Therefore, we

need not further consider the relative competence and responsibility of the two forums.

The case before us involves issue preclusion, not claim preclusion.[4] The rule of issue preclusion, derived from our earlier decisions, is as stated in *State Farm Fire & Cas. v. Reuter, supra:* If a claim is litigated to final judgment, the decision on a particular issue or determinative fact is conclusive in a later or different action between the same parties if the determination was essential to the judgment. 299 Or at 158.

We turn then to an examination of the issues decided

[3] Many other courts have applied the doctrine in workers' compensation cases. *See* 3 Larson, Workmen's Compensation Law § 79.72(a) & n 26 (1983), and cases cited therein.

[4] On claim preclusion and issue preclusion, see Restatement (Second) of Judgments, sections 17-29 (1980).

by the Board in the first hearing. The claimant sustained an injury to her hips on October 26, 1981, when she slipped on some steps at work. She asserted a claim. The employer's insurer paid medical benefits. Her claim was closed by determination order with an award of time-loss benefits on April 9, 1982. The claimant challenged the award, arguing that her claim was prematurely closed or, in the alternative, that she was entitled to permanent partial disability compensation. On June 15, 1982, a referee affirmed the closure and rejected the claim for permanent partial disability. With respect to the issue of premature closure, the referee not only concluded that the claimant was medically stationary but went on to state:

> "The relationship of claimant's current disability to her industrial injury is a medical question, and claimant has not sustained her burden of showing a medical connection between her present condition and her industrial injury. I therefore find that her claim was properly closed and she is not entitled to have her claim reopened."

With respect to her claim of entitlement to permanent partial disability, the referee found that the claimant did not sustain "her burden of proving that she has lost any earning capacity as a result of her industrial injury."

The Board affirmed and adopted the referee's opinion and order "subject to one comment":

> "The referee stated that 'One of Dr. Torres' main concerns seems to be claimant's fatty nodules, which he said are not

> related to claimant's bilateral hip discomfort.' A more accurate assessment of Dr. Torres' opinion is that he is unable to determine to what extent the nodules are related to the hip discomfort and the industrial injury. *This clarification is important in the context of this case because claimant's pain has continued since the injury but the etiology of the continuing pain problem has yet to be diagnosed.*" (Emphasis added.)

No appeal was taken from the Board's decision. The employer's insurer continued to pay medical benefits for over a year after the hearing before the referee. On July 23, 1983, after receiving additional medical information, the insurer issued a partial denial for medical conditions diagnosed as sacroiliitis, fibrositis, chronic back pain and bilateral hip girdle pain.

The claimant requested a hearing on the partial denial and further alleged that her injury had worsened. The referee upheld the partial denial with respect to the sacroiliitis, fibrositis and the chronic back pain; however, the referee directed the insurer to continue to pay for medical care and treatment of the claimant's ongoing hip girdle pain. The referee dismissed the claimant's aggravation claim because she had failed to show that the hip girdle condition had worsened since the last award or arrangement of compensation.

The Board affirmed, adopting the referee's opinion and order as its own. The insurer appealed, arguing that the doctrine of res judicata barred the claim and that "the Referee and the Board necessarily relitigated and inconsistently decided medical issues of causation previously determined in a final, litigated order."

In order to determine whether res judicata applies, we

must first examine in greater detail what was decided in the first adjudication. The claims asserted and the Board's first decision in the 1982 injury were these:

Claim	*Disposition*
For medical expenses for hip injury	Not in controversy. The medical expenses were being paid.[5]
For premature closure	Denied. Board held that the claim was properly closed.
For permanent partial disability arising from injury	Denied. The Board stated that although "claimant's pain has continued since the injury, * * * the etiology of the continuing pain problem has yet to be diagnosed."

After the first Board ruling the claimant continued to receive medical treatment and the employer continued to pay medical bills until July 23, 1983, when it issued a denial letter reading in part as follows:

> "A review of medical information obtained from Kip Kemple, M.D. and Kaiser Permanente reveals your disability is not related to your employment at North Clackamas School District No. 12 or the October 26, 1981 on-the-job injury. The medical condition for which we are partially denying has been diagnosed as sacroiliitis, fibrositis, chronic back pain and bilateral hip girdle pain. This partial denial is based on the fact it does not appear your condition was worsened by or arose out of and in the course of your employment, either by accident or occupational disease within the meaning of the Oregon workers' compensation law."

The claimant requested a hearing on the denial and claimed "an aggravation of her condition."

The Board in part upheld the denial. The Board adopted the opinion of the referee, which contains this finding:

> "I conclude that the medical evidence does not support the employer/adjuster's denial of responsibility for claimant's bilateral hip girdle pain and reverse the denial in that respect. However, I also conclude that the medical evidence does support the employer/adjuster's denial of responsibility for claimant's sacroiliitis, fibrositis and chronic back conditions."

Both the referee and the Board denied the worsening claim on the facts, but refused to hold that all future claims for aggravation were barred. The referee stated:

[5] ORS 656.262(9) provides that "[m]erely paying or providing compensation shall not be considered acceptance of a claim * * *." ORS 656.262(6) requires that the insurer or self-insured employer furnish a claimant with "[w]ritten notice of acceptance or denial * * * within 60 days after the employer has notice or knowledge of the claim." In this case, although the medical expenses were paid, the record contains no evidence of acceptance of the claim by the employer's insurer. Because the employer's insurer did not "specifically accept" the claimant's claim in writing, the rule against "back-up denials" stated in *Bauman v. SAIF*, 295 Or 788, 670 P2d 1027 (1983), is not implicated in this case. *Johnson v. Spectra Physics*, 303 Or 49, 55-56, 58, 733 P2d 1367 (1987). The employer's insurer, may, however, be subject to penalties under ORS 656.262(10) for not specifically responding to the claim within 60 days. *See id.* at 58-59.

"I do not, however, agree with the employer/adjuster that claimant's aggravation claim is barred by the prior litigation Orders. It is at least theoretically possible for a person with an accepted, initially non-disabling work injury condition to subsequently experience a compensable worsening of that condition. Since the prior litigation did not deal with the issue of aggravation or worsening, that litigation does not bar a subsequent claim by claimant for aggravation."

In holding that the Board's first decision barred the assertion of the worsening claim, the Court of Appeals stated:

"We do not agree with claimant's assertion that issues raised by her present claim are significantly different from those previously litigated. More than five months after the industrial accident a referee found that her then existing hip condition was unrelated to her initial compensable injury. That determination was affirmed by the Board and never appealed. The present case is unlike our decision in *Kepford v. Weyerhaeuser Co.*, 77 Or App 363, 713 P2d 625, *rev den* 300 Or 722 (1986), where the claimant offered a previously unlitigated theory. Here, the record contains no objective evidence distinguishing claimant's current hip condition from the hip malady which she had asserted in her original disability hearing. *Because entitlement to medical treatment and disability benefits result from work-related injuries, the underlying causation issues are essentially identical. The compensability of claimant's hip condition has already been determined.*"

85 Or App at 564 (emphasis added).

We disagree. No questions relating to the claimant's right to medical benefits were decided in the first hearing. Only two issues—premature closure and entitlement to permanent partial disability—were there involved. On the latter question, the Board found that the claimant had established no then-present permanent partial disability caused by the hip injury. The employer's insurer had never denied that the claimant had sustained an injury to the hip and there was no finding that the claimant had not sustained a hip injury.

As stated, the insurer continued to pay medical benefits until its partial denial letter of July 23, 1983. True, a carrier or employer can, at any time, deny, in whole or in part, claims for medical expenses or disability on the ground that they are unrelated to the injury claim theretofore accepted. *See Johnson v. Spectra Physics,* 303 Or 49, 58, 733 P2d 1367 (1987). But the Court of Appeals erred in holding that the partial denial was correct because of the preclusive effect of the Board's first adjudication. The referee's comments on this point are apposite, and we agree with them:

"The employer/adjuster makes a very tempting argument that it is absolved of future responsibility by the doctrine of res judicata. That is to say, it argues that since the issue of extent of permanent disability has been litigated and has led to a finding that claimant had no permanent residuals as a result of her work injury her compensable condition must therefore have completely resolved prior to the time of the last hearing. Having completely resolved, counsel goes on to argue, any problems claimant now has cannot be related to her industrial injury.

"Though the argument is tempting, to accept it would, in effect, cut off all of claimant's future rights for medical care

and treatment under ORS 656.245 and for aggravation under ORS 656.273, a result neither contemplated by the Legislature nor allowed by the Workers' Compensation Act."

The Court of Appeals' opinion seems to say that as a matter of law *all* of the claimant's claims, including the claim for medical expenses and worsening, are barred under the rules of res judicata. The finding of no permanent partial disability at the first decision does not bar all claims for aggravation under rules of res judicata. We read the first Board decision to find a hip injury, but no then present permanent partial disability. If the later aggravation claim is uncompensable, it is uncompensable because, as a matter of fact, there was no worsening when comparing the later hip condition with the earlier hip condition. This was the finding of the referee and the Board without the application of rules of res judicata.

Though we agree with the Court of Appeals that a claimant "cannot use an aggravation claim as a back door to relitigate underlying causation issues," 85 Or App at 563-64, that is not the case here. The finding of no permanent partial

disability at the first hearing did not bar the assertion of all later aggravation claims as a matter of law.

The decision of the Court of Appeals is reversed. The case is remanded to the Court of Appeals to decide, as a matter of fact, whether the claimant's hip condition has worsened and whether the insurer's denial of the need for further medical care and treatment was proper.[6]

[6] The claimant cross-petitioned in the Court of Appeals for judicial review of the Board's denial of compensation for her back pain. The Court of Appeals found that "her present back condition is the product of a preexisting condition which was not caused or affected by the industrial accident." *North Clackamas School District v. White*, 85 Or App 560, 564 n 2, 737 P2d 649 (1987). That issue is out of the case and should not further be considered.

IN THE SUPREME COURT OF THE
STATE OF OREGON

In the Matter of the Compensation of
Howard E. Hughes, Claimant.

GEORGIA-PACIFIC CORPORATION,
Petitioner on Review,

v.

HUGHES,
Respondent on Review.

(WCB 84-12107, CA A39769, SC S34107)

In Banc

On review from the Court of Appeals.*

Argued and submitted November 3, 1987.

George W. Goodman, McMinnville, argued the cause for petitioner on review. On the petition were Jerry K. Brown and Cummins, Cummins, Brown, Goodman & Fish, P.C., McMinnville.

Darren L. Otto, Salem, argued the cause for respondent on review. On the response was Ronald L. Bohy, Salem.

CAMPBELL, J.

The decision of the Court of Appeals is affirmed in part and reversed in part. The order of the Workers' Compensation Board is affirmed.

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* Judicial Review of Order of the Workers' Compensation Board. 85 Or App 362, 736 P2d 602 (1987).

CAMPBELL, J.

The principal issue in this Workers' Compensation case is whether the payment of an award of "interim compensation" is stayed pending an employer's or insurer's appeal of the award.

On April 16, 1982, claimant filed a stress-related occupational disease claim against Georgia-Pacific, a self-insured employer. Claimant did not work from that time until November 29, 1982. Georgia-Pacific denied the claim on July 8, 1983. It paid claimant no compensation between the time claimant filed and the time it denied the claim.

A Workers' Compensation Board referee concluded that claimant's claim was not compensable but that claimant was entitled to receive interim compensation pursuant to ORS 656.262 for the period between the claim's filing and its denial. Georgia-Pacific requested Board review of this determination and refused to pay the awarded interim compensation pending that review.

Claimant requested a hearing on Georgia-Pacific's refusal to pay. A second referee concluded that the interim compensation awarded was "compensation" within the meaning of ORS 656.313(4) and that, pursuant to ORS 656.313(1),

payment of that compensation was not stayed pending Georgia-Pacific's appeal. The referee awarded claimant penalties and attorney fees based upon the interim compensation awarded.

On review of the first referee's decision, the Board applied our newly minted opinion in *Bono v. SAIF,* 298 Or 405, 692 P2d 606 (1984), reducing the award of interim compensation to reflect only the period from April to November 1982, during which claimant was actually off work. On review of the second referee's decision, the Board agreed with the referee's conclusion that awards of interim compensation are not stayed, but reduced the penalty levied against the employer to conform to the modified interim compensation award.

The Court of Appeals agreed with the conclusion that interim compensation is not stayed pending appeal and that penalties were properly levied on the basis of the employer's refusal to pay pending appeal. *Georgia-Pacific v. Hughes,* 85 Or App 362, 736 P2d 602 (1987). However, the court reinstated

the entire penalty levied by the referee on the ground that *Bono* reflected a change in the law so that at the time the interim compensation was awarded, it was "then due" within the meaning of ORS 656.262(10). *Id.* at 367. For the reasons set out below, we affirm the Court of Appeals' conclusion that awards of interim compensation are subject to ORS 656.313, but reverse the reinstatement of that portion of the penalty stricken by the Board.

The relevant portions of ORS 656.313 read:

> "(1) Filing by an employer or the insurer of a request for review or court appeal shall not stay payment of compensation to a claimant.
>
> "* * * * *
>
> "(4) Notwithstanding ORS 656.005, for the purpose of this section, 'compensation' means benefits payable pursuant to the provisions of ORS 656.204 to 656.208 [Death and permanent total disability], 656.210 [Temporary total disability] and 656.214 [Permanent partial disability] and does not include the payment of medical services."

ORS 656.005(8) reads:

> " 'Compensation' includes all benefits, including medical services, provided for a compensable injury to a subject worker or the worker's beneficiaries by an insurer or self-insured employer pursuant to this chapter."

The issue in this case, therefore, is whether "interim compensation" payable in accordance with the provisions of ORS 656.262 qualifies as "compensation" within the meaning of 656.313(1). Georgia-Pacific argues that the interim compensation is paid "pursuant" to ORS 656.262 rather than one of the statutes specifically enumerated in ORS 656.313(4), and for this reason it is not subject to ORS 656.313(1). Georgia-Pacific maintains that had the legislature intended to include interim compensation in that definition it would have done so expressly. For the reasons set out below, we hold that interim compensation is compensation within the meaning of ORS 656.313 and that payment of an award of interim compensation is therefore not stayed pending the employer's appeal.

We begin by considering the nature of interim compensation. ORS 656.262 provides in relevant part:

"(2) The compensation due under this chapter shall be

paid periodically, promptly and directly to the person entitled thereto upon the employer's receiving notice or knowledge of a claim, *except where the right to compensation is denied by the insurer or self-insured employer.*

"* * * * *

"(4) The first instalment of compensation *shall be paid no later than the 14th day after the subject employer has notice or knowledge of the claim.* Thereafter, compensation shall be paid at least once each two weeks, except where the director determines that payment in instalments should be made at some other interval. * * *

"* * * * *

"(6) Written notice of acceptance or denial of the claim shall be furnished to the claimant by the insurer or self-insured employer within 60 days after the employer has notice or knowledge of the claim. *Pending acceptance or denial of a claim, compensation payable to a claimant does not include the costs of medical benefits or burial expenses.* * * *

"* * * * *

"(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."[1] (Emphasis added.)

In *Jones v. Emanuel Hospital,* 280 Or 147, 151, 570 P2d 70 (1977), this court held that "[s]ubsection (2), construed together with subsections (4) and (5) [now subsections 2, 4 and 6 of ORS 656.262] requires the employer to pay what may for convenience be called interim compensation payments until the employer denies the claim." In *Jones* the claimant filed a workers' compensation claim for temporary total disability based upon severe and debilitating cramps. The employer did not deny her claim until more than six months had passed.

During that period, the employer paid no compensation to the claimant. This court concluded that the provisions of ORS 656.262, read in combination, imposed upon an employer against whom a claim is made a duty either to deny the claim or to make interim payments of compensation pending action on the claim. Unless the employer has denied the claim, for whatever reason, on or before the 14th day after receiving notice or knowledge of the claim, payment of the first instalment of compensation under that claim must be paid on that day. The employer must continue making compensation pay-

[1] ORS 656.382(1) reads:

"If an insurer or self-insured employer refuses to pay compensation due under an order of a referee, board or court, or otherwise unreasonably resists the payment of compensation, the employer or insurer shall pay to the claimant or the attorney of the claimant a reasonable attorney fee as provided in subsection (2) of this section. To the extent an employer has caused the insurer to be charged such fees, such employer may be charged with those fees.

ments "at least once every two weeks" until it either accepts the claim (in which case payments continue) or denies the claim (in which case it may suspend payments pursuant to ORS 656.262(2)). This duty arises regardless of whether the claim is ultimately found to be compensable.[2] 280 Or at 151-52.

In *Bono v. SAIF, supra,* this court reaffirmed *Jones,* but recognized that payment of interim compensation was dependent upon its calculability. Where the compensation is not otherwise calculable, the provisions of ORS 656.210 should be used.

> "It is not necessary for a worker to be totally disabled in

> order to receive interim compensation. Any claim for a disabling compensable injury will trigger the ORS 656.262(4) payments. However, to the extent that the amount of such payments cannot be calculated, the worker should receive as interim compensation the temporary total disability benefits specified in ORS 656.210."

298 Or at 410. Temporary total disability payments are calculated on the basis of time loss. Where the claimant has lost no time, the payments are not calculable.

> "The purpose of interim compensation is to compensate the injured worker for leaving work. This is true even where this results from a non-compensable injury, as in *Jones.* However, if the worker does not demonstrate that he or she left work, interim compensation is not required."

298 Or at 410.

We next consider the purposes of ORS 656.313(4). We first note that while subsection (4) states that for the purposes of subsection (1) " 'compensation *means*' " the listed statutes, it specifically *excludes* only medical services from its coverage. (Emphasis added.) The legislative history of this provision reveals the reasons for this. The legislature in 1979 added subsections (3)[3] and (4) to ORS 656.313 for the specific

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[2] In *Jones* this court read ORS 656.262 as "giv[ing] the employer two choices: deny the claim or make interim payments." 280 Or at 151. The court read the statute as denying the employer

> "a third choice: to delay acceptance or denial of the claim while making no interim payments. This third choice would delay the worker's appeal from an adverse decision since the worker cannot appeal until he or she receives the notice of denial. ORS 656.262(6). During this time, the worker would receive no benefits; thus, the employer would be able to gamble on the ultimate outcome of the case and at the same time delay that outcome. We decline to adopt such an interpretation of the statute and hold that the word 'compensation' includes interim compensation."

Id. In the instant case, Georgia-Pacific made precisely that prohibited "third choice." Here Georgia-Pacific would have us hold that not only may the employer fail to pay compensation pursuant to the schedule mandated in ORS 656.262(4), it may withhold those payments throughout the appeals process. In the words of the *Jones* court, Georgia-Pacific's argument "does violence to the intent of the statute." 280 Or at 151. In *Jones,* this court held that the employer's mere refusal to pay, interim compensation pursuant to the statutory schedule constituted unreasonable refusal to pay, and justified penalties pursuant to ORS 656.262(10) and attorney fees pursuant to ORS 656.382(1). The issue of whether an employer's appeal stays payment of interim compensation should never arise, because if a claim was filed, if the employer did not deny it within 14 days and if the compensation was calculable, the compensation should already have been paid pursuant to the schedule in ORS 656.262(4). Nothing in the statutes permits the employer to withhold those payments.

purpose of overruling the Court of Appeals' decision in *Wisherd v. Paul Koch Volkswagen,* 28 Or App 513, 559 P2d 1305 (1977). *Wisherd* held that because the definition of "compensation" in ORS 656.005 includes "medical services", ORS 656.313 applied to awards of medical benefits and required their "immediate payment * * * by virtue of the order when the order is entered." 28 Or App at 517. The Senate committee that adopted the amendment specified "on the record that this is not an attempt to deny payment or require coverage of *any form* of compensation *other than medical services,*" Minutes, Senate Committee on Labor, Consumer and Business Affairs (June 12, 1979) (emphasis added). ORS 656.313(4) is thus consistent with the provision in ORS 656.262(6), added by the 1981 legislature, that "[p]ending acceptance or denial of a claim, compensation payable to a claimant does not include the costs of medical benefits * * *." There is, consequently, no reason to conclude that ORS 656.313(4) was intended to exclude interim compensation from subsection (1)'s coverage if it is otherwise properly considered "compensation."

ORS 656.003 provides that "[e]xcept where the context otherwise requires, the definitions given in this chapter govern its construction." Both ORS 656.262(4) and (6) refer to the payments made pending the employer's acceptance or denial of the claim as "compensation." They are calculated and paid in the same manner as the "compensation" required to be paid during the appeals process. ORS 656.262 creates no independent substantive basis for compensation—it simply sets out the mechanism and procedure to be adhered to in paying the compensation due pursuant to the substantive provisions of the statutes enumerated in ORS 656.313(4). ORS 656.262 in essence creates a presumption, pending the employer's action on the claim, that a claim is for a "compensable injury" and that the claimant is entitled to compensation until and unless the employer denies the claim. This situation is not substantively different from the situation in which a referee's determination that a claim is compensable is ultimately reversed on appeal. The injury was in such a case thus never truly "compensable." ORS 656.313, however, requires that it be regarded as such pending appeal.

[3] ORS 656.313(3) reads:

"If an insurer or self-insured employer denies the compensability of all or any portion of a claim submitted for medical services, the insurer or self-insured employer shall send notice of the denial to each provider of such medical services and to any provider of health insurance for the injured worker. "After receiving notice of the denial, a medical service provider may submit medical reports and bills for the disputed medical services to the provider of health insurance for the injured worker. The health insurance provider shall pay all such bills in accordance with the limits, terms and conditions of the policy. If the injured worker has no health insurance, such bills may be submitted to the injured worker. A provider of disputed medical services shall make no further effort to collect disputed medical service bills from the injured worker until the issue of compensability of the medical services has been finally determined. When the compensability issue has been finally determined or when disposition of the claim has been made pursuant to ORS 656.289(4), the insurer or self-insured employer shall notify each affected medical service provider and each affected health insurance provider of the results of the determination, including the results of proceedings under ORS 656.289(4) and the amount of any settlement. If the services are determined to be compensable, the insurer or self-insured employer shall reimburse each health insurance provider for the amount of claims paid by the health insurance provider pursuant to this section. Such reimbursement shall be in addition to compensation or medical benefits the worker receives. Medical service reimbursement shall be paid directly to the health insurance provider. As used in this subsection, 'health insurance' has the meaning for that term provided in ORS 731.162."

In *Jones* this court saw "no reason to hold that 'compensation' as used in ORS 656.382 [which refers to "compensation due under an order of a referee, board or court"] has a

meaning different from 'compensation' as used in ORS 656.262." 280 Or at 153. We similarly see no reason to conclude that its meaning differs from "compensation" as used in ORS 656.313. We therefore conclude that the compensation required pending an employer's action on a claim is subject to ORS 656.313(1), and that an award of unpaid interim compensation is not stayed pending the employer's appeal.

Though Georgia-Pacific's petition does not specifically address the Court of Appeals reinstatement of the entire penalty levied by the second referee, we regard such a challenge as implicit in its arguments regarding the definition of "compensation." We disagree with the Court of Appeals' conclusion that the Board erred in reducing Georgia-Pacific's penalty to reflect the reduction in interim compensation that was mandated by our decision in *Bono*. The Court of Appeals reasoned:

> "ORS 656.262(10) authorizes a penalty for an unreasonable delay or refusal to pay compensation on amounts 'then due.' At the time when the second referee assessed a penalty, the amount 'then due' was the full amount of interim compensation. The fact that that amount was later reduced by the Board due to a change in the law does not alter the fact that, when the compensation was due, employer refused to pay it. Therefore, the second referee properly assessed a penalty on the full amount of interim compensation which had been awarded by the first referee."

85 Or App at 367.

The flaw in the court's reasoning is the statement that *Bono* changed the law regarding interim compensation. In fact, *Bono* merely clarified a point that is implicit in the statutes and in *Jones*—that compensation cannot be paid when there is no basis upon which to calculate it. That part of the referee's award of unpaid interim compensation, compensating claimant during a period when he was working, was never due. Consequently, Georgia-Pacific cannot be penalized for not having paid it.

The decision of the Court of Appeals is affirmed in part and reversed in part. The order of the Workers Compensation Board is affirmed.

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