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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.

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41 Van Natta ____ (1989)

RALPH E. MOEN, Claimant
Max Rae, Claimant's Attorney
Brian Whitehead, Attorney
Merrily McCabe (SAIF), Defense Attorney

WCB 86-15963 & 87-05149
July 5, 1989
Order on Review

Reviewed by the Board en banc.

Claimant requests review of those portions of Referee Myers' order that: (1) declined to award temporary disability benefits during claimant's incarceration, from the date of the order, September 18, 1987, until claimant's release from custody; and (2) declined to assess a penalty and related attorney fee for the SAIF Corporation's alleged unreasonable unilateral termination of temporary disability benefits while claimant was incarcerated. SAIF also moves to strike those portions of claimant's brief, which cites as fact claimant's entitlement to temporary disability while incarcerated. On review, the issues are temporary disability, and penalties and attorney fees. We affirm in part, and reverse in part.

SAIF moves to strike those portions of claimant's brief which states as follows: "Claimant was entitled to and received time loss compensation when he was incarcerated. (Tr 14)." Respondent argues that claimant attempts to characterize what is properly a conclusion of law as a statement of fact in his "Statement of Facts" section. Claimant testified at hearing that since the date of incarceration he had received a portion of a time loss check in early November of 1985. Accordingly, appellant's reference to this fact in his statement of facts was not improper. SAIF's motion to strike is denied.

FINDINGS OF FACT

We adopt the Referee's findings of fact.

CONCLUSIONS OF LAW

Temporary disability

The Referee first concluded that SAIF's unilateral termination of temporary disability benefits was improper, and that SAIF was obligated to pay temporary disability payments from the date of incarceration, October 25, 1985, until the date of the order. Secondly, the Referee concluded that claimant was not entitled to temporary disability benefits during the period of incarceration, because he was not substantively entitled to such benefits under Cutright v. Weyerhaeuser Co., 299 Or 290 (1985), and Karr v. SAIF, 79 Or App 250 (1986). Accordingly, SAIF was authorized to suspend claimant's temporary disability benefits from the date of the order, until claimant's release from incarceration.

SAIF does not challenge the Referee's conclusion on the first issue, while claimant disagrees with the Referee's second conclusion. We hold that the Referee's suspension of temporary disability benefits from the date of the order until claimant's release from custody was improper.

At the time SAIF terminated claimant's temporary disability benefits, claimant was not medically stationary, and his claim had neither been closed administratively, nor by Determination Order. Furthermore, claimant has not returned, nor been released, to regular work. Under these circumstances, we find that the insurer's

termination of benefits was improper. Northrup King & Co. v. Fisher, 91 Or App 602 (1988); Volk v. SAIF, 73 Or App 643, 646 (1985); Jackson v. SAIF, 7 Or App 109 (1971). SAIF must continue to pay temporary disability until the case is ready for closure. At that time, claimant's entitlement to temporary disability benefits during incarceration may be addressed. Northrup King & Co. v. Fisher, supra. The remedy for wrongful unilateral termination is award of the benefits. The Referee was without authority to suspend compensation retroactive prior to claim closure. Therefore, the Referee's ruling on this issue was premature and we decline to address the applicability of the Cutright analysis to these facts. See Ernest F. McGhee, 40 Van Natta 1764 (1988).

Alternatively, if the Referee had the authority to suspend claimant's compensation, we conclude that claimant's incarceration would not provide justification for such a suspension. Inasmuch as claimant was medically unable to work as a result of his compensable injury, he remained entitled to temporary total disability benefits. Ted W. Peckham, 41 Van Natta 609 (March 27, 1989).

Penalties and attorney fees

The Referee concluded that SAIF's reliance upon an opinion letter by an Assistant Attorney General, which indicated that an incarcerated inmate is not entitled to temporary disability benefits was not unreasonable, and therefore, would not support a penalty and related attorney fee. We agree, and add that although we find that SAIF's unilateral termination of benefits invalid for reasons stated above, we conclude that at the time it terminated claimant's benefits, such an action taken in 1985 in reliance upon the Assistant Attorney General's opinion was not unreasonable. See Lloyd O. Fisher, 39 Van Natta 5 (1987).

ORDER

The Referee's order, dated September 18, 1987, is affirmed in part, and reversed in part. That portion of the order which limited claimant's entitlement to temporary total disability is reversed. Claimant is awarded temporary disability benefits beginning October 25, 1985, and continuing until such benefits are terminated pursuant to law. Claimant's attorney is awarded 25 percent of the increased compensation created by this order. However, the total attorney fees payable out of claimant's compensation to be awarded by the Referee and Board orders shall not exceed $3,800. The remainder of the Referee's order is affirmed.

Board Member Ferris, dissenting:

I dissent from that portion of the majority's decision which holds that claimant was entitled to temporary disability benefits during the period of his incarceration.

As SAIF concedes, its unilateral termination of temporary disability benefits was improper. See Northrup King & Company v. Fischer, 91 Or App 602 (1988). However, by seeking a Referee's order permitting it to terminate claimant's temporary disability benefits during his incarceration, I submit that SAIF invoked the jurisdiction of the Hearings Division pursuant to ORS 656.283(1). This procedure is not unlike that recommended by the Fisher court when it stated that "[i]f employer believed that claimant was not entitled to benefits during his incarceration, it should have requested a hearing." Northrup King & Company v. Fisher, supra, at page 606.

Once vested with jurisdiction, the Referee correctly concluded that claimant was not entitled to temporary disability benefits during the period of his incarceration. As I stated in my recent dissent in Ted W. Peckham, 41 Van Natta 609 (March 27, 1989), Cutright v. Weyerhaeuser, 299 Or 290 (1985) and its progeny stand for the following propositions: (1) temporary total disability benefits are intended to provide wage replacement for a worker; (2) when the claimant has withdrawn from the work force, for whatever reason, he or she is no longer a worker; (3) if the claimant is no longer a worker, he or she cannot lose wages and, consequently, is not entitled to temporary total disability benefits. the basic reasoning behind these propositions was succinctly articulated by the Supreme Court in Cutright:

> "There is not one word in the statute that refers to a person who no longer engages in furnishing services for remuneration. Certainly, one who retires voluntarily form the work force is no longer a 'worker' as defined [by former ORS 656.005(28), now 656.005(27).]." Cutright, supra, 299 Or at page 297.

In Karr v. SAIF, 79 Or App 250 (1986), the Court of appeals followed the Cutright analysis, stating:

> "Whatever the reason, claimant has withdrawn from the work force. Temporary total disability is awarded for lost wages . . . and a person who has withdrawn from the work force has no lost wages."

The court has continued to apply this analysis. For example, in Dawkins v. Pacific Motor Trucking, 91 Or App 562 (1988), the court stated:

> "Claimant contends that his withdrawal from the labor market should not preclude an award of temporary total disability, because it was involuntary and was the result of his work-related disability. As we held in Karr v. SAIF, (citation omitted) a claimant who withdraws from the work force is not entitled to those benefits, which are awarded for lost wages. ORS 656.210(1); Sykes v. Weyerhaeuser Co., 90 Or App 41 (1988). a person who has withrawn from the labor market, whether as a result of his injury or for other reasons, has no lost wages."

Finally, as stated by the Supreme Court, temporary disability benefits are maintenance benefits intended to provide support and help replace lost income during the healing or recovery process. Cutright, supra, at page 302. Inasmuch as an incarcerated claimant is provided food and lodging and is unable to furnish services for remuneration, I submit that there is no entitlement to temporary disability benefits during this period of withdrawal from the work force. Instead, I would adhere to the basic precept advanced by Cutright and the other aforementioned cases. That is, a claimant who has withdrawn from the work force,

for whatever reason, is no longer a worker and cannot lose earnings. Therefore, although entitled to medical benefits resulting from the compensable condition, the "withdrawn" claimant is not entitled to temporary total disability benefits.

I would affirm the Referee's order.

ROBERT WALLAGE, Claimant
Malagon, et al., Claimant's Attorneys

Own Motion 87-0247M
July 5, 1989
Own Motion Order

SAIF Corporation initially submitted this matter to the Board for consideration pursuant to ORS 656.278. Claimant's aggravation rights had expired. The Board postponed action on the request for own motion relief until resolution of WCB Case No. 87-00777, then pending in the Hearings Division. By stipulation, the parties agreed that SAIF would pay claimant a penalty on the unpaid medical bills, authorize a CT scan and pay claimant's attorney a fee. Claimant now asks that the Board proceed with the request for own motion relief, contending that he is entitled to benefits under the provisions of the own motion law in effect at the time of the original request.

Although claimant's request for claim reopening was submitted and pending in 1987, the claim was not reopened prior to January 1, 1988. Therefore, processing of the request is subject to the current version of ORS 656.298(1)(a). See Susan A. Bagwell, 40 Van Natta 1062 (1988); Andy Webb, 40 Van Natta 586 (1988). Pursuant to ORS 656.278(1)(a), we may exercise our "Own Motion" authority to award temporary disability benefits only when we find that there is a worsening of a compensable injury that requires either inpatient or outpatient surgery or other treatment requiring hospitalization. Here, claimant underwent a CT scan. We have previously held that a CT scan is a diagnostic procedure, not treatment nor surgery. See Susan A. Bagwell, supra. Accordingly, we conclude we are without authority to grant the relief claimant seeks. The request for own motion relief is hereby denied.

IT IS SO ORDERED.

JAMES G. ADAMS, Claimant
Peter O. Hansen, Claimant's Attorney
Cooney, Moscato & Crew, Defense Attorneys
Rankin, et al., Defense Attorneys
Roberts, et al., Defense Attorneys
Daryll E. Klein, Defense Attorney

WCB 86-08747, 86-01876, 86-08746 & 85-15626
July 7, 1989
Order on Remand

This matter is before the Board on remand from the Court of Appeals. Giusti Wine Co. v. Adams, 94 Or App 175 (1988). The court has determined that claimant's request for hearing on EBI Companies' aggravation denial was not timely. Hence, the court has remanded for our determination of whether claimant had good cause for filing a late request for hearing.

Additionally, United Pacific Insurance Company (United Pacific) requests on remand that we dismiss the "consolidated Requests for Hearing" as they relate to United Pacific. We note, however, that the Referee had already dismissed the hearing request against United Pacific based on the joint stipulation of all the parties at hearing.

Hence, we interpret United Pacific's current request as a request to be dismissed as a party to this proceeding on remand. We deny that request. United Pacific remains a "party" to this proceeding, though it may elect to be a nominal party. See Zurich Ins. Co. v. Diversified Risk Management, 300 Or 47 (1985).

FINDINGS OF FACT

On August 19, 1985, EBI sent its denial letter by certified mail, return receipt requested, to claimant's correct address. Claimant resided at that address until September 1, 1985. The post office left notices at the address on August 21 and 27. However, claimant did not receive those notices. Almost two months later, the denial letter was sent to another address and received by the wrong person with the same name. On October 29, 1985, EBI mailed a second denial letter to claimant. Claimant received it on November 4. He filed a request for hearing on both denials on December 18, 1985, almost four months after the first denial letter was mailed.

FINDING OF ULTIMATE FACT

Claimant had good cause for filing a late request for hearing.

CONCLUSIONS OF LAW AND OPINION

The test for determining if good cause exists has been equated to the standard of "mistake, inadvertance, surprise or excusable neglect" recognized under ORCP 71B(1) and former ORS 18.160. Anderson v. Publishers Paper Co., 78 Or App 513, 517, rev den 301 Or 666 (1986); see also Brown v. EBI Companies, 289 Or 455 (1980). Claimant has the burden of proving good cause. Cogswell v. SAIF, 74 Or App 234, 237 (1985).

Claimant testified that he never received the post office's notices regarding the certified denial letter of August 19, 1985. The Referee found claimant to be credible, and we find no reason to disturb that finding on review. Accordingly, we find that, despite reasonable diligence, claimant did not receive actual notification of the denial until he received the second letter on November 4, 1985. Because claimant could not be expected to file a request for hearing on the denial prior to that date of notification, we find good cause for his delay in filing the hearing request. The hearing request is not barred. See ORS 656.319(1)(b).

ORDER

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

Board Member Ferris, dissenting:

I disagree with the majority's conclusion that claimant has established good cause for his failure to request a hearing within 60 days from the date of mailing of EBI's first denial. The denial letter was correctly addressed to claimant and sent by certified mail, return receipt requested. Two post office notices were left at his address.

The 60-day period to request a hearing begins to run from the date of mailing of the denial, not from the date of actual

notification. Guisti Wine Co. v. Adams, 94 Or App 175 (1988), Wright v. Bekins Moving & Storage Company, 97 Or App 45 (June 14, 1989). Thus, claimant's hearing request, submitted some four months after the first denial, was untimely under ORS 656.319(1)(a).

I do not consider claimant's alleged failure to receive post office notices of the certified letter as good cause because, if it is, the 60-day statutory period would in effect begin to run from the date that a claimant received notice. The Wright court has recently reasoned that such a principle is directly contrary to the Supreme Court's interpretation of ORS 656.319(1) in Norton v. Compensation Department, 252 Or 75 (1968).

Finally, I note that claimant did not testify that he did not receive the post office notices. Rather, he stated that he did not recall seeing the notices. Such circumstances do not persuade me that claimant exercised reasonable diligence in this matter. Accordingly, I would reverse that portion of the Referee's order that found that claimant's hearing request from EBI's denial was not barred for untimeliness.

JEFFREY A. DOMBEK, Claimant
Carney, et al., Claimant's Attorneys
Schwabe, et al., Defense Attorneys

WCB 87-05313
July 7, 1989
Order on Review

Reviewed by the Board en banc.

The insurer requests review of those portions of Referee Peterson's order that: (1) found that claimant's hearing request from its denial of claimant's back injury was timely filed; and (2) assessed a penalty and attorney fee for the insurer's allegedly late and unreasonable denial. We affirm.

ISSUES

1. Whether claimant timely requested a hearing on the insurer's denial of his claim.

2. If claimant did not timely request a hearing on the denial, whether claimant showed "good cause."

3. Whether a penalty and attorney fee should be assessed for the insurer's allegedly late and unreasonable denial.

FINDINGS OF FACT

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

Claimant did not notify the insurer of his change of address in December 1986 from Newberg, Oregon to Vancouver, Washington.

CONCLUSIONS OF LAW

Timeliness of Hearing Request

The Referee found that claimant's hearing request was timely, based on Charles H. Whiddon, 39 Van Natta 407, reconsidered 39 Van Natta 811 (1987). In that case, we held that failure to request a hearing on a denial within the 60-day

limitations period provided under ORS 656.319(1)(a) does not render a request untimely if notice of the denial is not "delivered," i.e., received by claimant. Id. at 811. However, the Court of Appeals recently reversed that decision, holding that the date of mailing starts the running of the 60-day period, whether or not the notice is received. United Foam Corp. v. Whiddon, 96 Or App 178 (1989). Here, claimant filed his hearing request more than three months after the denial letters were mailed. Hence, the hearing request was untimely under ORS 656.319(1)(a).

We now determine whether claimant had good cause for failing to file a timely hearing request. See ORS 656.319(1)(b). The test for determining if good cause exists has been equated to the standard of "mistake, inadvertance, surprise or excusable neglect" recognized under ORCP 71B(1) and former ORS 18.160. Anderson v. Publishers Paper Co., 78 Or App 513, 517, rev den 301 Or 666 (1986); see also Brown v. EBI Companies, 289 Or 455 (1980). Claimant has the burden of proving good cause. Cogswell v. SAIF, 74 Or App 234, 237 (1985).

Here, claimant persuasively testified that he did not receive notice of the denial until four to five months after the denial letters were mailed. He requested a hearing two days later. The long delay preceding claimant's receipt of the notice of denial supports a finding of good cause for claimant's late hearing request.

The insurer responds that claimant did not exercise due diligence in apprising the employer or insurer that he had moved to a new address in Vancouver, Washington, in December, 1986. The insurer argues that, without that notification, there was no way to advise claimant of the denial. We disagree.

Claimant first reported the industrial injury to the employer in July, 1986. The insurer then had 60 days within which it was required to furnish claimant written notice of its acceptance or denial of the injury claim. See ORS 656.262(6). During that time, the insurer knew claimant's correct address; yet, no timely notice of acceptance or denial was sent. By December, 1986, when claimant moved to the Washington address, four to five months had already elapsed since he had reported the injury to the employer. As the Referee stated: "The insurer's argument that the claimant was duty bound to notify it of any address change does not hold much water because if the insurer had issued its denial within the sixty (60) days required by the statute, there would not have been this problem." We adopt that reasoning here and find that claimant had good cause for filing an untimely hearing request.

Penalty and Attorney Fee

We adopt the second paragraph in the "OPINION" portion of the Referee's order as our conclusion of law.

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

ORDER

The Referee's order dated November 5, 1987 is affirmed. The Board approves a client-paid fee, payable from the insurer to its attorney, not to exceed $474.50.

Board Member Ferris, dissenting:

I dissent. The insurer issued a denial on November 14, 1986, and December 19, 1986. Both were sent by certified mail and both were returned "unclaimed". Although claimant never received the insurer's denial letters, they were mailed. Therefore, claimant's request for hearing on April 3, 1987 was untimely. See Guisti Wine Co. v. Adams, 94 Or App 174 (1988) and Wright v. Bekins Moving & Storage Company, 97 Or App 45 (June 14, 1989).

Claimant argues that he is excused from his failure to request a hearing within 60 days of the insurer's November and December denials because he never received notice of them until April 1, 1987, when his treating doctor told him that his claim had been denied. Claimant did not receive the November denial, which was mailed to his Tigard address, because he had just moved from Tigard to Newberg, Oregon. He had previously informed the insurer that, if he could not be contacted in Tigard, it should attempt to contact him at his father's Newberg address. Therefore, the insurer directed its December 1989 denial to the Newberg address. At that time, however, claimant had moved to Vancouver, Washington. He did not inform the insurer of this second change of address from Newberg to Vancouver, Washington.

Since we have previously held that a claimant has an obligation to inform the insurer of any address change, see Richard T. Reilley, 37 Van Natta 1192, 1198 (1985), and claimant did not do so, claimant has not established good cause for his failure to timely request a hearing in the present case.

MICHELLE J. ALLEN, Claimant
Haugh, et al., Claimant's Attorneys
Schwabe, et al., Defense Attorneys

WCB 87-15911
July 11, 1989
Order on Review

Reviewed by Board Members Ferris and Crider.

Claimant requests review of Referee Thye's order that affirmed a Determination Order that awarded no permanent disability for a right hand condition. We affirm.

ISSUE

Extent of scheduled permanent partial disability for a right hand condition.

FINDINGS OF FACT

Claimant, a griddle cook, filed a disabling occupational disease claim for right carpal tunnel syndrome (CTS) in July 1986. The claim was accepted. Dr. Thayer, an orthopedist, performed carpal tunnel release in October 1986. In January, 1987, she was released to regular work with resolving numbness on the ulnar side of the long finger. Thayer declared her medically stationary with

no permanent impairment on January 26, 1987. The claim was closed by Notice of Closure on January 30, 1987, with no permanent disability award. The Notice of Closure was affirmed by Determination Order.

We adopt the fifth paragraph of the Referee's order with the following supplement. One to two months after returning to regular work in January, 1987, claimant began experiencing right hand symptoms, including thumb "locking," a "burning" sensation and constant aching in the thumb and palm. She was treated with steroid injections and splints. The aching persisted at the time of hearing. The symptoms restrict her ability to lift and twist with the right hand.

ULTIMATE FINDING OF FACT

Claimant's current right hand symptoms are not related to the compensable right CTS.

CONCLUSIONS OF LAW AND OPINION

To establish her entitlement to a scheduled permanent disability award for current right hand symptoms claimant must prove that the accepted right CTS is a material contributing cause of those symptoms and that she is permanently disabled as a result thereof. ORS 656.214(2; Destael v. Nicolai Co., 80 Or App 595, 600 (1986). There is no medical evidence relating current right hand symptoms to CTS; rather, they have been variously diagnosed as right thumb muscle strain, "locking trigger thumb," chronic inflammation of the basal joint and carpal metacarpal joint problems. In April and July, 1987, while claimant presumably continued to experience symptoms, Dr. Thayer reported that the right CTS was "OK" and "fine."

The relationship between current symptoms and right CTS presents a complex medical question, particularly in light of evidence that the CTS had resolved without impairment. Hence, resolution of this case turns largely on the medical evidence. Uris v. Compensation Department, 247 Or 420, 426 (1967); Kassahn v. Publishers Paper Co., 76 Or App 105, 109 (1985). The medical evidence does not relate current symptoms to the compensable CTS. We conclude, therefore, that claimant has failed to sustain her burden of proving that the accepted CTS condition materially contributed to her current hand symptoms. Accordingly, she is not entitled to a scheduled disability award for the disabling effects of those symptoms.

ORDER

The Referee's order dated March 10, 1988 is affirmed. The Board approves a client-paid fee not to exceed $1,000.

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

WCB 87-08331
July 11, 1989
Order on Review

Reviewed by the Board en banc.

Claimant requests review of Referee Menashe's order that dismissed her request for hearing for failure to appear.

The Board affirms and adopts the order of the Referee.

ORDER

The Referee's order dated January 4, 1988 is affirmed. The Board approved a client-paid fee, payable from the insurer to its attorney, not to exceed $1,216.50

Board Member Crider, dissenting:

On November 24, 1987, the parties were notified that this case was scheduled for hearing on December 22, 1987. On the appointed date, claimant's attorney appeared. However, claimant did not. Claimant's attorney moved for a postponement on the ground that he had been unable to reach claimant and that, apparently, she was out of the country temporarily. The request to postpone was denied. The referee dismissed the request for hearing.

Former OAR 438-06-070 authorized dismissal of a request for hearing for failure to appear in the absence of good cause. Claimant did not fail to appear. She appeared through counsel. There is no jurisdictional requirement that claimant personally appear. Eberet Williams, 41 Van Natta 466 (1989); Warren F. Stier, 36 Van Natta 334 (1984). Therefore, in the absence of some exploration of the nature of the issues in order to determine whether or not claimant's personal attendance was indispensable, no dismissal order should have been entered. John M. Barbour, 36 Van Natta 304 (1984).

Even if the rule required claimant to appear personally, claimant is entitled to an opportunity to establish that she had good cause for failure to appear. It has been our practice, when a claimant states extenuating circumstances in her request for review, to remand for hearing to determine whether or not there was good cause for her failure to appear. Janet Stanfill, 40 Van Natta 1108 (September 2, 1988). That procedure should be followed here.

For that reason also, I dissent.

NANCY C. EVENHUS, Claimant
Brian R. Whitehead, Claimant's Attorney
Cliff, Snarskis, et al., Defense Attorneys
Acker, et al., Defense Attorneys

WCB 87-04881, 87-03084 & 87-03085
July 11, 1989
Order Denying Reconsideration

Liberty Northwest Insurance Corporation has requested reconsideration of that portion of our June 15, 1989 Order on Review that affirmed a Referee's order finding it responsible for claimant's left knee condition. Specifically, Liberty Northwest questions our reference to "the second insurer" on page four of our order.

On June 28, 1989, Liberty Northwest filed its petition for judicial review of our June 15, 1989 order. Consequently, jurisdiction to consider this matter has vested with the Court of Appeals.

We have previously held that it is possible to withdraw an order after the filing of a petition for judicial review. Dan W. Hedrick, 38 Van Natta 208, 209 (1986). However, we exercise this authority rarely. Ronald D. Chaffee, 39 Van Natta 1135 (1987).

Under these circumstances, we decline to exercise this

authority and withdraw our June 15, 1989 order. Accordingly, the motion for reconsideration is denied. The issuance of this order neither "stays" our prior order nor extends the time for seeking review. International Paper Company v. Wright, 80 Or App 444 (1986); Fischer v. SAIF, 76 Or App 656 (1985).

IT IS SO ORDERED.

MICHAEL W. JOHNSON, Claimant
Susan Connolly, Claimant's Attorney
Brian Pocock, Defense Attorney

WCB 85-13549
July 11, 1989
Order on Review

Reviewed by Board Members Crider and Ferris.

Claimant requests review of that portion of Referee Nichols' order that upheld the SAIF Corporation's denial of his claim for a collapsed right lung. The issue on review is compensability. We affirm.

FINDINGS OF FACT

Claimant was employed at a plywood mill as a relief and cleanup worker. In June, 1985, he was assigned to assist cleaning a dryer which contained dust and caustic ash. The next morning he had chest pain and a cough. He continued to work. On August 27, 1985, while at work, he suffered a collapsed right lung (pneumothorax). After one month, he retuned to work at the plywood mill. He quit after three days, for reasons unrelated to his physical condition, and went to work for a different employer. He was not exposed to dust or caustic ash while working for the new employer.

He again suffered a collapsed right lung in January, 1986, and September, 1986. He was treated surgically after the September 1986, incident. Surgery revealed no trauma and no damage from dust or caustic ash.

Pneumothorax conditions most often occur in the right lung of young men. They are usually idiopathic, or follow a trauma to the chest. Claimant does not suffer lung disease or damage as a result of inhaling caustic ash.

ULTIMATE FINDING OF FACT

The preponderance of the evidence does not establish a causal relationship between claimant's work activities and his right lung condition.

CONCLUSIONS OF LAW AND OPINION

The Referee found that claimant had failed to prove a causal relationship between his work activities and his right lung condition. She based her conclusion on the opinions of Drs. Ironside and Girod, who opined that claimant's condition is idiopathic and spontaneous, as opposed to the opinions of Drs. Meharry and Kurihara, who indicated claimant's condition was work related. We agree with the Referee.

The question of causation in this case presents a complex medical question, requiring expert medical opinion. See Kassahn v. Publishers Paper, 76 Or App 105 (1985). We usually defer to the opinion of the treating physician, unless significant

reasons exist to do otherwise. Taylor v. SAIF, 75 Or App 583, 585 (1985). Here, we find there are persuasive reasons to rely on opinions other than that of the treating physician.

The reports of Dr. Meharry, family physician and Dr. Kurihara, general surgeon, present mere possibilities of how claimant's work activities might have contributed to his right lung pneumothorax condition. See Gormley v. SAIF, 52 Or App 1055 (1981). These opinions, particularly Dr. Kurihara's, offer only theories regarding compensabilility.

On the other hand, the reports and deposition testimony of Dr. Girod, infectious disease specialist, and Dr. Ironside, pulmonary specialist, establish with some certainty the unlikelihood that claimant's work activities could have contributed to his condition. Dr. Ironside described claimant as a classic case of spontaneous, idiopathic pneumothorax in the right lung of a young male. As did the Referee, we find the opinions of Dr. Girod and Dr. Ironside persuasive. Consequently, we conclude that claimant has failed to prove the compensability of his right lung condition.

ORDER

The Referee's order dated July 17, 1987 is affirmed.

DONNA E. ASCHBACHER, Claimant
Doblie & Associates, Claimant's Attorneys
Scheminske & Lyons, Defense Attorneys

WCB 88-07257
July 13, 1989
Order on Review

Reviewed by the Board en banc.

Claimant requests review of Referee Knapp's order that upheld the insurer's denial of her occupational disease claim for a low back condition. The issue is compensability. We reverse.

FINDINGS OF FACT

Claimant, 52 years of age at hearing, has worked as a phlebotomist for the past 20 years. Her work requires that she be on her feet much of her eight-hour work day. She had worked full time for a number of years for the employer but quit in 1980. She attended school for a time and then returned to work for the employer again in June 1984 on a two-to-three-day-per-week schedule.

In December 1987, claimant experienced the gradual onset of right calf pain. The pain would appear approximately four hours into claimant's work shift. By March 1988, her symptoms had increased and would appear earlier in the work day. Claimant missed a number of days of work in March due to increased symptoms.

During this period of time, claimant was taking off-work walks of approximately one hour in duration almost daily.

Claimant's treating physician, Dr. Reynolds, referred claimant to Dr. Waller, neurosurgeon. Dr. Waller had claimant undergo an MRI scan which disclosed foraminal stenosis, or narrowing, at L5-S1 on the right. The narrowing of the foramen was caused by a degenerative bony spur. This condition results in nerve root irritation when claimant is active for extended periods

of time. It is this nerve root irritation which causes claimant's leg symptoms.

Claimant left work with the employer on April 4, 1988 due to her increased pain. As of the date of hearing, she had not returned to her employment.

Claimant continues to experience right leg pain when she is active for extended periods of time.

FINDINGS OF ULTIMATE FACT

Claimant suffers from a degenerative foraminal stenosis condition which was neither caused nor worsened in material part by her work exposure. However, claimant's work activities materially contributed to increased symptoms of her preexisting condition which were disabling and required medical services.

CONCLUSIONS OF LAW AND OPINION

Applicable Law

In 1987, the Oregon Legislature enacted an extensive revision of the law relating to occupational diseases. Or Laws 1987, ch. 713, s. 4. The new law became effective January 1, 1988. Or Laws 1987, ch. 713, s. 8. Claimant first experienced the onset of leg symptoms in December 1987. She first sought medical treatment and became disabled from work in March 1988. Therefore, the first issue we must address is whether this case is governed by the occupational disease law in effect in 1987 or the law that became operative January 1, 1988. The Referee decided in favor of application of the new law. We agree.

ORS 656.202(2) provides:

> "Except as otherwise provided by law, payment of benefits for injuries or deaths under ORS 656.001 to 656.794 shall be continued as authorized, and in the amounts provided for, by the law in force at the time the injury giving rise to the right to compensation occurred." (Emphasis supplied.)

In addition, ORS 656.804 provides:

> "An occupational disease *** is considered an injury for employes of employers who have come under ORS 656.001 to 656.794, except as otherwise provided in ORS 656.802 to 656.824."

The Court of Appeals addressed the question of when the "injury" resulting from an occupational disease occurs in Johnson v. SAIF, 78 Or App 143, rev den 301 Or 240 (1986). Claimant in Johnson had been exposed to airborne asbestos fibers from December 1941 through December 1942. He filed a claim for asbestos-related disease in 1983. Occupational diseases were not compensable under Oregon's Workers' Compensation Law before July 1, 1943.

The court held in Johnson that, for purposes of ORS 656.202(2), the "injury" resulting from an occupational disease

occurs on the date of last exposure. Id. at 148. Because claimant's last exposure had occurred prior to July 1, 1943, the Court found that claimant did not have a compensable claim.

Here, the injurious exposure alleged by claimant is the extensive standing and walking inherent in her job duties. Claimant continued to perform her job duties until April 4, 1988. Therefore, in accordance with Johnson v. SAIF, supra, the "injury" resulting in her claim for an occupational disease occurred after January 1, 1988. The new law is applicable.

Compensability

As revised by the 1987 Legislative Assembly, ORS 656.802(1) defines occupational disease as:

> "(a) any disease or infection arising out of and in the course of employment caused by ingestion of, absorption of, inhalation of or contact with dust, fumes, vapors, gasses, radiation or other conditions or substances to which an employe is not ordinarily subjected or exposed other than during a period of regular actual employment therein, and which requires medical services or results in disability or death.
>
> "(b) Any mental disorder arising out of and in the course of employment and which requires medical services or results in physical or mental disability or death.
>
> "(c) Any series of traumatic events or occurrences arising out of and in the course of employment which requires medical services or results in physical disability or death."

In order to qualify as a compensable occupational disease, the claim must be for a condition which meets one of the three definitions set forth in ORS 656.802(1). Claimant argues that her condition is compensable under subsection (1)(c). We agree that her condition is compensable, if at all, as the result of a "series of traumatic events or occurrences arising out of and in the course of [claimant's] employment." We rely in this regard upon Dr. Waller's deposition testimony to the effect that claimant's symptoms result from repetitive microtrauma to the nerve root.

We next address the question of the degree of work contribution necessary to establish a compensable claim made pursuant to ORS 656.802(1)(c). In this regard, prior to the 1987 revisions, ORS 656.802(1)(a) defined an "occupational disease" as follows:

> "Any disease or infection which arises out of and in the scope of the employment, and to which an employee is not ordinarily subjected or exposed other than during a period of regular actual employment therein." (Emphasis supplied.)

In Dethlefs v. Hyster Co., 295 Or 298 (1983), the Court interpreted the underscored language to require proof by a preponderance of the evidence that a claimant's work exposure is the major cause of a disease before the disease will be found compensable. Id. at 310. We will refer to the underscored language as the "Dethlefs language."

The Dethlefs language was not retained in current ORS 656.802(1)(b) or (c). The Referee concluded that, under subsections (b) and (c), a worker no longer need prove that work exposure was the major cause of a disease in order to establish a compensable claim. Rather, the Referee determined that a worker need only prove that work exposure was a material contributing cause of the condition. Therefore, on review we must decide whether deletion of the Dethlefs language in subsections (b) and (c) means that the "major cause" test is no longer applicable to those categories of occupational diseases.

Our analysis must commence with the language of the statute itself. Whipple v. Howser, 291 Or 475, 479 (1981). If the language of the statute expresses the probable legislative intent, then resort to "rules" or "maxims" of statutory construction are unnecessary. Id. at 483. We conclude in this regard that the language of ORS 656.802(1) clearly and unambiguously expresses the intent of the legislature.

The Dethlefs language was retained in current ORS 656.802(1)(a). Therefore, in order to prove a compensable "disease or infection" involving "ingestion of, absorption of, inhalation of or contact with dust, fumes, vapors, gasses, radiation or other conditions or substances," a claimant must establish that work exposure, as compared to off-work exposure, was the major cause of the disease or infection. See De Witt v. Rissman, 218 Or 549 (1959) (when legislature reemploys language from prior statute in new statute, it is presumed legislature intended same judicial construction repeatedly placed upon earlier enactment).

However, only subsection (a) of current ORS 656.802(1) contains the Dethlefs language. To interpret subsections (b) and (c) as retaining the "major cause" standard would require us to read the Dethlefs language into those subsections. This approach would contravene the legislature's directive in ORS 174.010, which provides:

> "In the construction of a statute, the office of the judge is simply to ascertain and declare what is, in terms or in substance, contained therein, not to insert what has been omitted, or to omit what has been inserted; and where there are several provisions or particulars such construction is, if possible, to be adopted as will give effect to all." (Emphasis supplied.)

The courts will insert omitted language only where it can be clearly seen that to do so is necessary to effectuate the legislative intent. Lane County v. Heintz Const. Co., 228 Or 152, 160 (1961). Legislative intent to include the "major cause" burden of proof in subsections (b) and (c) does not clearly appear

on the face of the statute. Therefore, we look to the legislative history of current ORS 656.802(1) to determine whether a clear intent to retain that standard can be divined. Before doing so, we note that "circumstantial evidence of legislative intent must be considered in the light most favorable to the work[er]." Buell v. SIAC, 238 Or 492, 496 (1964).

ORS 656.802(1), then House Bill 2271, was filed presession by the House Task Force on Occupational Disease, an interim committee. Section 4 of the bill is the provision which sets forth the new tripartite definition of occupational disease. As originally drafted, none of the three subsections included the Dethlefs language. During the first public hearing of the bill before the House Committee on Labor, witnesses pointed out that exclusion of the Dethlefs language from the proposed definitions could lead the courts to conclude that occupational diseases need only result in material part from work place exposures in order to be found compensable. Minutes, House Committee on Labor (March 6, 1987).

The House Labor Committee's examination of HB 2271 resumed on March 25, 1987. At that time, the Committee had before it a hand-engrossed version of the bill which now included the Dethlefs language in proposed subsection (a). However, the new version of the bill did not include the Dethlefs language in either subsection (b) or (c).

Our review of the legislative history does not disclose why the Dethlefs language was reinserted into subsection (a) and not into subsections (b) and (c). It may have been intentional. It may have been inadvertent. However, there is an inference in this regard that when language is included in one provision and omitted from another provision, such omission was deliberate. Oregon Business Planning Council v. LCDC, 290 Or 741, 749 (1981). This is particularly true where, as here, the legislature has been informed of the possible results flowing from omission of the language. Minutes, Senate Committee on Labor (April 23, 1987) (Ex. B). In addition, we note that it would have been a simple matter for the legislature to have inserted the Dethlefs language in all three subsections of ORS 656.802(1). See Whipple v. Howser, supra, 291 Or at 486.

Moreover, as expressed by the Court in Monaco v. U.S. Fidelity & Guar., 275 Or 183, 188 (1976):

> "Whatever the legislative history of an act may indicate, it is for the legislature to translate its intent into operational language. This court cannot correct clear and unambiguous language for the legislature so as to better serve what the court feels was, or should have been, the legislature's intent."

In sum, in light of the legislative intent apparent from the face of the statute to retain the major cause standard only for claims made under current ORS 656.802(1)(a), and in the absence of a clear expression of intent to the contrary, we conclude that an injured worker need prove that his or her work exposure was a material, rather than major, cause of the condition in order to establish a compensable claim under ORS 656.802(1)(b) and (c).

The Referee reached the same conclusion on this issue as we have reached. However, citing Weller v. Union Carbide, 288 Or 27 (1979), the Referee stated that claimant must also prove a worsening of her underlying condition in order to prevail. The Referee determined that claimant had failed to prove that her work activities caused a worsening of her degenerative foraminal stenosis. He concluded that claimant had failed to sustain her burden of proof. Consequently, we must decide whether Weller remains applicable under current ORS 656.802(1)(c).

The facts in Weller are similar to those here. Claimant in Weller experienced degenerative changes in the bone structure of his lower spine. These degenerative changes caused nerve root irritation which resulted in low back and leg pain. Claimant's work neither caused nor worsened his underlying disease, but claimant's work did cause pain. Claimant argued that so long as his work activity resulted in pain which caused disability, he had proven a compensable occupational disease. The Court disagreed.

The Court held that to prevail claimant would need to prove by a preponderance of evidence that (1) his work activity and conditions (2) caused a worsening of his underlying disease (3) resulting in an increase in his pain (4) to the extent that it produces disability or requires medical services. Id. at 35. Citing Sahnow v. Fireman's Fund Ins. Co., 260 Or 564 (1971), the Court considered itself bound by the Court of Appeals' factual determination that claimant's work had not caused a worsening of his underlying degenerative condition. Consequently, the Court found that claimant had failed to establish element (2), a worsening of the underlying condition.

The occupational disease claim at issue in Weller was argued under former ORS 656.802(1)(a). Claimant contends that the Weller rule is not applicable under current ORS 656.802(1)(c). Claimant reasons that the Weller rule is dependent upon language in former ORS 656.802(1)(a), which defined an "occupational disease" as "[a]ny disease or infection." This "disease or infection" language was omitted from current ORS 656.802(1)(c). Instead, subsection (1)(c) refers only to repetitive trauma requiring medical services or causing disability.

Neither party refers us to any legislative history regarding the intent of the legislature in omitting the "disease or infection" language from subsection (1)(c). Nor does our independent review of the legislative history preceding adoption of Oregon Laws 1987, chapter 713, section 4, disclose any relevant discussion of this issue. Consequently, we are unable to refer to legislative history as an interpretive aid in resolving this dispute.

There does exist, however, judicial precedent which provides some guidance on this question. In particular, shortly after deciding Weller, the Court was confronted with an analogous situation in Wright v. SAIF, 289 Or 323 (1980). Claimant in Wright was a former fire fighter who filed a claim for heart and respiratory conditions. The diagnosis and cause of these conditions was undetermined. However, it was established that claimant's job activities "stimulated" claimant's pain.

One of the issues before the Court was whether, under the Weller rule, claimant needed to prove that his work activities and exposures worsened his underlying conditions. The Court noted

that the statutes relevant to the Weller decision were former ORS 656.005(8), former ORS 656.802(1)(a), and ORS 656.804. The Court stated that these statutes "make an 'injury,' 'disease or infection' compensable if it either requires medical services or results in disability." Wright, supra, 289 Or at 334.

The Court next examined former ORS 656.802(1)(b) which defined "occupational disease" pertaining to fire fighters as:

> "Death, disability or impairment of health of fire fighters ***, caused by any disease of the lungs or respiratory tract, hypertension or cardiovascular-renal disease, and resulting from their employment as fire fighters."

The Court also examined former ORS 656.802(2), which provides, in part:

> "Any condition or impairment of health arising under paragraph (b) of subsection (1) of this section shall be presumed to result from a fire fighter's employment ***."

The Court then concluded that the Weller rule was inapplicable to the firefighter's presumption in former ORS 656.802(1)(b) and (2). The Court reasoned:

> "ORS 656.802(1)(b) provides that an 'occupational disease' means 'death, disability or impairment of health of firemen ***.' (emphasis added) The language of ORS 656.802(2) provides that 'any condition or impairment of health,' arising under 656.802(1)(b) is presumed to result from a fireman's employment. This language is markedly different from the terms 'injury, disease, or infection,' and includes in the presumption of compensability a worsening of symptoms as well as a worsening of the underlying disease. To read the words 'impairment of health' to exclude symptomatology would ignore the all-inclusive phrase chosen by the legislature ***."

The Court's analysis in Wright is applicable here. As adopted by the legislature, ORS 656.802(1)(c) provides that an occupational disease means "[a]ny series of traumatic events or occurrences ***." This language is markedly different from the "[a]ny disease or infection" language contained in former ORS 656.802(1)(a) (retained in current ORS 656.802(1)(a)). Moreover, as in Wright, to read the words "[a]ny series of traumatic events or occurrences *** which requires medical services or results in physical disability or death" to exclude symptomatology would ignore the all-inclusive phrase chosen by the legislature.

We conclude that, pursuant to current ORS 656.802(1)(c), a claimant need not prove a worsening of a preexisting condition in order to establish a compensable claim. Rather, a claimant

need only show an increase in symptoms of a preexisting condition if the other requirements of the statute are met.

Therefore, we conclude that under current ORS 656.802(1)(c), claimant need prove that her work exposure was a material contributing cause of either increased symptoms or a worsening of her underlying condition requiring medical services or resulting in disability.

Turning to the facts of this case, the evidence is persuasive that claimant's work activities as a phlebotomist were a material contributing cause of increased symptoms from her foraminal stenosis condition. In this regard, claimant first experienced the onset of leg and foot symptoms while at work. In addition, the symptoms occurred after a number of hours spent on her feet. Further, Dr. Waller acknowledged that claimant's walking and standing activities, which she performed extensively while at work, would have a microtraumatic effect on the nerve root, thereby producing pain. Moreover, the insurer does not dispute that claimant's work activities resulted in increased symptoms of her underlying disease. We, therefore, find that claimant has established a compensable claim under ORS 656.802(1)(c).

Claimant's counsel is statutorily entitled to a reasonable, insurer-paid attorney fee for services rendered at hearing and on Board review. See ORS 656.386(1). Such a fee is defined as an "assessed fee." See OAR 438-15-005(2). However, we cannot authorize an assessed fee unless claimant's attorney files a statement of services. See OAR 438-15-010(5). While claimant's attorney filed a statement of services for his representation of claimant at the hearings level, no statement of services has been received for his services on Board review. Therefore, an assessed fee for services at the Board level shall not presently be authorized. See OAR 438-15-010(5).

ORDER

The Referee's order dated September 26, 1988 is reversed. The insurer's April 13, 1988 denial is set aside and the claim is remanded to the insurer for processing in accordance with law. Claimant's attorney is awarded an assessed fee of $2,000 for his services at hearing, to be paid by the insurer. The Board approves a client-paid fee, not to exceed $1,673.

Board Member Ferris, concurring in part and dissenting in part:

I concur in that portion of the majority opinion which holds that the 1987 amendments to ORS 656.802 are applicable to this case. I disagree with much of the majority's interpretation of those amendments, however, and would uphold the insurer's denial of claimant's claim. I would rule that a claimant must prove that work activity or exposure was the "major contributing cause" of the claimed condition under paragraphs (b) and (c) of ORS 656.802(1) as well as under paragraph (a). I would also rule that the requirements of Weller v. Union Carbide Corp., 288 Or 27 (1979) are applicable to cases under all three paragraphs.

I.

The majority rules that a claimant who claims an

occupational disease under paragraph (a) of ORS 656.802(1) must prove that work activity or exposure was the "major contributing cause" of the claimed condition, but that a claimant who claims an occupational disease under paragraph (b) or (c) of the same subsection need only prove that work activity or exposure was a "material contributing cause" of the claimed condition. The basis for this conclusion is the appearance of what the majority calls the "Dethlefs language" ("to which an employe is not ordinarily subjected or exposed other than during a period of regular actual employment therein") in paragraph (a) and its absence from paragraphs (b) and (c). The majority also holds that this difference reflects such a clear and unambiguous legislative intent to require a higher quanta of contribution for paragraph (a), than for paragraphs (b) and (c), that the Board, and presumably the courts are precluded from even questioning this interpretation through an examination of legislative history.

I agree with the majority that the presence of the Dethlefs language in paragraph (a) reflects a clear and unambiguous intent to retain the "major contributing cause" quantum of contribution for claims under that paragraph. I disagree, however, that the absence of that language from paragraphs (b) and (c) ipso facto establishes a legislative intent to require some lesser quantum of contribution for claims under those paragraphs. Had the Legislature specified "material contributing cause" as the quantum of contribution under paragraphs (b) and (c), the matter would be clear and unambiguous; there would be no room for argument. The Legislature did not do this; paragraphs (b) and (c) are silent regarding the applicable quantum of contribution. Silence is seldom golden when it comes to legislation. Ordinarily, such silence is soon broken by a number of discordant interpretations. The present statute is no exception.

One possible interpretation of the Legislature's silence in paragraphs (b) and (c) of ORS 656.802(1) is that adopted by the majority. At least two other plausible interpretations readily come to mind, however. First, in view of the traditional "major contributing cause" standard for all occupational disease claims, the clear retention of this quantum of contribution for claims under paragraph (a) and the absence of any apparent reason for a different quantum of contribution for claims under paragraphs (b) and (c), the silence in paragraphs (b) and (c) may reasonably be interpreted to mean "major contributing cause." Second, even assuming with the majority that the absence of the Dethlefs language from paragraphs (b) and (c) was meant to convey some meaning other than "major contributing cause," it can be interpreted to mean "sole cause" as well as "material contributing cause." Regardless of which of the above interpretations may be the most reasonable on the face of the statute, several interpretations are plausible. The legislative history of ORS 656.802 must be consulted to resolve this ambiguity.

The amendments to ORS 656.802 were part of 1987 House Bill 2271. The impetus for HB 2271, and a number of other bills introduced during the 1987 legislative session, was the "Oregon Comeback" plan initiated by Governor Neil Goldschmidt. One of the primary goals of this plan was to streamline and otherwise reduce the cost of the workers' compensation system in Oregon in order to attract or retain business for the state. In accordance with this

general purpose, one of the major objectives of HB 2271 was to restrict the compensability of mental stress claims. Tape Recording, Senate Committee on Labor, April 23, 1987, Tape 120, Side A at 164-66 (statement of Representative Shiprack, Chairman of the House Committee on Labor).

When HB 2271 was originally introduced, none of the paragraphs of the revised definition of an occupational disease contained the Dethlefs language or any other language expressing a quantum of contribution applicable to claims under the section. During public hearings conducted on the bill by the House Committee on Labor, some of the witnesses pointed out that the absence of such language created an ambiguity. Tape Recording, House Committee on Labor, March 6, 1987, Tape 49, Side A at 446-85 (testimony of Mr. Francesconi); Id., Tape 48, Side B at 27-52 (testimony of Mr. Snarskis). One of these witnesses noted that if this ambiguity was construed to mean "material contributing cause," it would be much easier for claimants to establish the compensability of all occupational diseases, including stress-related mental disorders, and that this would be contrary to one of the major purposes of HB 2271. Id. at 89-95.

In response to these comments, the Committee amended the definition by adding the Dethlefs language to paragraph (a) of ORS 656.802(1). Minutes, House Committee on Labor, March 25, 1987, p. 1 (Exhibit A, Hand-Engrossed HB 2271). Although the same language was not also added to paragraphs (b) and (c), discussion of the amendment between members of the Committee and between the Committee and witnesses before it establishes beyond any reasonable doubt that the purpose of the amendment was to retain the major contributing cause standard for all occupational disease claims, not just for those under paragraph (a). Tape Recording, House Committee on Labor, March 25, 1987, Tape 69, Side A at 42-72, 253-360; id., Side B at 404-40. Subsequent comments by counsel for the Senate Committee on Labor regarding the application of the major contributing cause standard to stress claims under paragraph (b) further reinforce this conclusion. Tape Recording, Senate Committee on Labor, June 9, 1987, Tape 202, Side A at 300-330 (statement of Committee Administrator Crider).

Given this history, it is apparent that the Legislature declined to add the Dethlefs language to paragraphs (b) and (c) either through an oversight or because of an assumption that the change in paragraph (a) would apply equally to paragraphs (b) and (c). Such an assumption was not unreasonable given "catchall" language appearing in paragraph (a): "Any disease or infection . . . caused by . . . contact with . . . conditions or substances." If read broadly, this language would encompass any disease claimed under paragraph (b) or (c).

Whatever the reason for the Legislature's failure to resolve the ambiguity regarding the applicable quantum of work contribution under paragraphs (b) and (c) of ORS 656.802(1), the question which the Board now faces is whether it has the authority to resolve that ambiguity in accordance with the intent clearly established by the legislative history. The majority answers this question in the negative on the theory that to do so would usurp legislative authority. It cites the prohibition in ORS 174.010 against inserting in statutes what the Legislature has omitted and emphasizes various "inferences" gleaned from a rather cursory reading of the case law relating to principles of statutory

construction. The majority misconstrues these authorities and ignores other authorities which effectively command what the majority refuses to do.

The most fundamental and cardinal of all of the principles of statutory construction is to discern and declare the intent of the Legislature. Fifth Avenue Corp. v. Washington County, 282 Or 591, 596 (1978); Berry Transport v. Heltzel, 202 Or 161, 165-66 (1954). Employing any secondary principle of statutory construction to defeat the purpose of the Legislature is to usurp legislative authority. Id. at 165. The starting point for determining legislative intent, of course, is the language of the statute itself. Whipple v. Howser, 291 Or 475, 479 (1981). When that language is ambiguous, however, a reviewing body has a duty to discern legislative intent from the legislative history of the statute and any other reliable sources and then to carry out that intent. Easton v. Hurita, 290 Or 689, 694 (1981); Curly's Dairy v. Department of Agriculture, 244 Or 15, 20-21 (1966).

ORS 174.010, the statute cited by the majority, and ORS 174.020, a related section not mentioned by the majority, are codifications of these fundamental principles. ORS 174.020 declares in pertinent part: "In the construction of a statute the intention of the legislature is to be pursued if possible." ORS 174.010 amplifies this basic principle: "In the construction of a statute, the office of a judge is simply to ascertain and declare what is, in terms or in substance, contained therein, not to insert what has been omitted, or to omit what has been inserted."

The majority concludes that to rule that the major contributing cause standard is applicable to claims under paragraphs (b) and (c) of ORS 656.802(1), would be to insert in the statute something that the Legislature omitted. The opposite is the truth. The Legislature clearly intended the major contributing cause standard to apply to all categories of occupational disease. It added language intended to effect that purpose to paragraph (a). Paragraphs (b) and (c) are ambiguous regarding the applicable quantum of contribution. Under these circumstances, the Board would not be adding anything to paragraphs (b) and (c) by resolving the ambiguity in those paragraphs in favor of the major contributing cause interpretation. By refusing to so interpret paragraphs (b) and (c), the majority is in fact omitting something that the Legislature inserted. It is refusing "to ascertain and declare what is, in terms or in substance, contained therein." ORS 174.010.

The majority's reliance on Monaco v. U.S.F. & G. Co., 275 Or 183 (1976) and Oregon Business Planning Council v. LCDC, 290 Or 741 (1981) is similarly misplaced. In Monaco, the Court refused to "correct clear and unambiguous language for the legislature so as to better serve what the court fe[lt] was, or should have been, the Legislature's intent." 275 Or at 188. Unlike the statutory language in Monaco, the language of ORS 656.802(1)(b) and (c) is not "clear and unambiguous"; it requires judicial interpretation, not legislative correction. In Oregon Business Planning Council v. OLCC, the Court stated that when the Legislature includes an express provision in one statute, but omits such a provision in another statute, it may ordinarily be inferred that the difference in the statutes was intended to have some significance. 290 Or at 749. Any such "inference" in the

present case is refuted by the legislative history. The majority improperly employs this secondary rule of statutory construction to defeat the primary purpose of such construction, namely, to discern and declare the intent of the Legislature.

A further difficulty not addressed by the majority is the arbitrary distinctions which its reading of ORS 656.802(1) creates between different categories of occupational disease. The majority's interpretation requires a claimant who claims an occupational disease under paragraph (b) or (c) to prove a lesser work connection than a claimant who claims an occupational disease under paragraph (a). What is the logic for such a distinction? I can imagine no rational basis for saying categorically that one quantum of work contribution should apply to diseases caused by "toxic exposure" and that another, lesser quantum of contribution should apply to diseases caused by mental stress or repetitive trauma. In that regard, the majority's conclusion is akin to requiring the application of the major contributing cause standard to claimants who break their right legs and the material contributing cause standard to claimants who break their left legs. The Legislature clearly did not intend such a result. Paragraphs (b) and (c) should be construed in a manner consistent with the unambiguous language of paragraph (a) to avoid the anomalous and probably unconstitutional interpretation reached by the majority. See Easton v. Hurita, supra, 290 Or at 694; Pacific Power & Light Co. v. State Tax Commission, 249 Or 103, 110 (1968).

To sum up, the result reached by the majority is unnecessary, unjust and contrary to the intent of the Legislature. In fact, particularly with regard to mental stress claims under ORS 656.802(1)(b), the majority accomplishes precisely the opposite of what the Legislature intended. Such claims can now be proven by evidence of a single occupational incident or exposure not otherwise excluded under ORS 656.802(2) which contributes more than a de minimis amount to the development or worsening of a mental disorder. See Patitucci v. Boise Cascade Corp., 8 Or App 503, 507 (1972). Such a rule is more likely to produce an "Oregon Exodus" than the "Oregon Comeback."

II.

The majority also rules that a claimant may prove a compensable occupational disease under paragraph (c) of ORS 656.802(1) by showing a worsening of the symptoms of a preexisting disease without also establishing a worsening of the underlying condition. In so ruling, it jettisons the longstanding rule of Weller v. Union Carbide Corp., 288 Or 27 (1979) on a basis inconsistent with the rationale of that decision and without so much as a whisper in the legislative history that such a result was intended.

The majority concludes that the rule of Weller v. Union Carbide Corp. is inapplicable to claims under paragraph (c) of ORS 656.802(1) because that paragraph does not contain the phrase "disease or infection" which appeared in the prior version of the statute. One searches the Weller decision in vain, however, for any reliance on this phrase. In fact, at one point in the decision, the Court stated that the "disease or infection" element of former ORS 656.802(1)(a) was satisfied by the preexisting disease which the claimant alleged had been worsened by work

activity. Immediately after quoting the text of the statute, the Court stated:

> "At first blush it would appear that the disease itself must arise out of the employment, but we have interpreted the statute otherwise. In Beaudry v. Winchester Plywood Co., 255 Or 503, 469 P2d 25 (1970), we squarely held that a disability resulting from worsening of a preexisting bursitis by the claimant's work activities and conditions was compensable under the Occupational Disease Law." 288 Or at 31.

A careful reading of the remainder of the Supreme Court's decision and of the Court of Appeals' opinion which it affirmed establishes that the Court's decision turned not on the phrase "disease or infection," but rather on the phrase "arises out of . . . employment." As the Court of Appeals explained in its Weller decision:

> "To have a compensable occupational disease, claimant must establish that his work [activity] originally caused or materially and permanently worsened his [underlying] condition. It is not sufficient merely to establish that claimant's work [activity] required him to make certain motions which caused his underlying condition to be symptomatic, i.e., caused pain. Otherwise, any person with common idiopathic conditions such as rheumatism, arthritis or bursitis whose job required painful movements would have a compensable occupational disease. 'Arises out of' in [former] ORS 656.802(1)(a) requires that the disease be caused or materially worsened by employment activity; merely showing that employment produces symptoms of nonindustrial disease (or of unknown causation) is insufficient." 35 Or App 355, 359 (1978).

Before the Supreme Court, the claimant and an amicus curiae attacked the Court of Appeals' reasoning on several fronts. First, they contended that the Supreme Court, in its Beaudry decision, had already determined that a symptomatic exacerbation of a preexisting condition was compensable as an occupational disease. The Court rejected this argument. 288 Or at 32-33. They then argued that the same conclusion followed from several other Supreme Court decisions which involved awards of permanent disability for disabling pain. In disposing of this argument, the Court said:

> "It is urged that this line of cases stands for the proposition that disability caused by pain which is, in turn, caused by work activity and conditions is compensable. We do not agree. In [those cases] we dealt with claims for compensation for disability caused by pain resulting from injury, which was, in turn, caused by work activity. In

> each of those cases a work-induced, pathological change was established, and the court dealt with a claim that pain resulting therefrom had caused the asserted disability. There is nothing before us to require qualification of what we said in those cases, but we find them of no avail to this claimant." 288 Or at 35 (emphasis in original).

Having disposed of the major arguments of the petitioner and the amicus curiae, the Court gave its classic statement of the elements of former ORS 656.802(1)(a) as applied to a claim for the worsening of a preexisting condition:

> "[I]n order to prevail claimant would have to prove by a preponderance of the evidence that (1) his work activity and conditions (2) caused a worsening of his underlying disease (3) resulting in an increase in his pain (4) to the extent that it produces disability or requires medical services." Id. (emphasis added).

The emphasized portions of the above quotation reflect that the Supreme Court, like the Court of Appeals, read the phrase "arises out of . . . employment" in former ORS 656.802(1)(a) as contemplating not only a causal connection between the claimant's work activity and his disabling symptoms, but also a causal connection between the work activity and a pathological effect upon the claimant's underlying disease. This conclusion is further reinforced by the final paragraphs of the opinion. In those paragraphs, the Court commented upon certain words chosen by the Court of Appeals to describe the magnitude of the worsening necessary in cases like Weller and disavowed that a permanent worsening was required. Id. at 36-37. Otherwise, however, it approved of and affirmed the Court of Appeals' opinion.

In considering the effect of the 1987 amendments to ORS 656.802(1) on the rule of Weller v. Union Carbide Corp., it is important to note that all three paragraphs of the amended subsection contain the phrase "arising out of . . . employment." It was this phrase, not the phrase "disease or infection," which the Weller Court construed to require proof of a worsening of the claimant's underlying condition. The majority's conclusion that the amendments did away with this requirement with respect to paragraph (c), therefore, is a mistake resulting from a misreading of the Weller decision.

It should also be noted that the phrase "disease or infection" does appear in paragraph (a). Under the majority's interpretation of Weller, therefore, a claimant who asserts a claim under paragraph (a) must prove a worsening of his underlying condition. Once again, the majority creates distinctions between different categories of occupational disease which have no basis in reason or in the legislative history.

The majority attempts to bolster its interpretation of Weller with Wright v. SAIF, 289 Or 323 (1980), a case involving the "fire fighter's presumption." In that case, the Court

construed the phrase "impairment of health" in former ORS 656.802(1)(b) to include symptomatology without any requirement of a worsening of the underlying condition. In dicta, the Court distinguished Weller on the ground that the expression "impairment of health" was much broader than the term "injury" in former ORS 656.005(8) or the phrase "disease or infection" in former 656.802(1)(a). 289 Or at 334-35. The majority grasps at this straw in an effort to save it foundering logic.

Wright fails, however, to keep the majority's argument afloat. ORS 656.802(1)(c) does not contain the phrase "impairment of health" or any equivalent expression. Instead, it employs the word "traumatic." The dictionary defines "trauma" as "an injury or wound to a living body caused by the application of external force or violence." Webster's Third New International Dictionary 2432 (unabridged 1961)(emphasis added). Inherent in the Legislature's choice of the word "traumatic," therefore, is a requirement of some kind of physical damage to the tissues of the claimant's body; proof of mere symptoms is not enough. Hence, even assuming that the errant dicta in Wright somehow constrains the misinterpretation of Weller adopted by the majority, far from rescuing the majority, Wright takes it down for the third time.

III.

Until the appellate courts have the opportunity to address the issues decided in this case, I note that nothing in the majority's interpretation of ORS 656.802(1) requires a carrier which must accept a worsening of the symptoms of a claimant's underlying condition to also accept the underlying condition itself. A claim for angina pain caused by work activity, for instance, does not automatically render the claimant's underlying heart condition compensable. Once the symptomatic worsening subsides and the underlying condition returns to its preexacerbation state, any causal relation between the underlying condition and work activity ceases to exist and the carrier's responsibility for the underlying condition ends. In such a case, therefore, the carrier could accept the claimant's claim for transient symptoms, close that claim by notice of claim closure or otherwise and then issue a partial denial of the underlying condition.

In the present case, claimant's work activity was a material contributing cause of symptoms in her right leg. These symptoms appeared whenever she was active for an extended period of time. Claimant left work and sought medical evaluation of her problem. The symptoms which claimant experienced as a result of her work activity disappeared soon after she left work. Subsequent symptomatic exacerbations were the result of work around her home. Ultimately, it was determined that claimant's symptoms were due to a degenerative low back condition which had neither been caused nor pathologically worsened by her work activity. Claimant's doctor proposed surgery for this condition. Given these facts, any causal connection between claimant's underlying degenerative condition and her work activity vanished once the symptoms caused by her work activity subsided. The insurer, therefore, is not responsible for any ongoing disability or medical treatment associated with claimant's underlying nonindustrial condition.

ELLEN L. CRAWFORD, Claimant
Michael B. Dye, Claimant's Attorney
Rick Dawson (SAIF), Defense Attorney

WCB 88-11895
July 13, 1989
Order on Review

Reviewed by the Board en banc.

Claimant requests review of Referee Howell's order that upheld the SAIF Corporation's denial of her occupational disease claim for a stress-related mental disorder. We affirm.

ISSUES

1. Whether the 1987 amendments to ORS 656.802 are applicable to this case.

2. The compensability of claimant's mental disorder.

FINDINGS OF FACT

Claimant began working as a psychiatric aide for the employer, Fairview Training Center, in 1977. In 1982, she was promoted and placed in charge of Holman Cottage, one of the buildings housing the agency's mentally retarded population. In this position, she supervised four or five other psychiatric aides on the graveyard shift. From 1982 through September 1987, claimant was supervised by Pat McClellan and received satisfactory peformance appraisals. Beginning in October 1987, Lynda Hickman replaced McClellan as claimant's supervisor.

In November 1987, claimant reported to Hickman and Hickman's supervisor, Dennis Heath, that one of the aides under her supervision, Becky Benniger, was not fully cooperating with her or following her instructions. Hickman and Heath met with claimant and Benniger on November 19, 1987 to discuss the problem. During the meeting, Hickman and Heath learned that the conflict between claimant and Benniger went back several years to a quarrel between Benniger and claimant's daughter. Claimant's daughter had worked at Holman Cottage until the quarrel occurred and then was transferred elsewhere. Claimant had harbored a grudge against Benniger ever since that event. Upon learning of the personal nature of the conflict between claimant and Benniger, Hickman and Heath took no action against Benniger and encouraged claimant to develop a more constructive attitude toward her. Claimant became angry, insisted that her relationship with Benniger would not improve and stated that she would not supervise Benniger anymore, that she would simply ignore her from that time forward.

Hickman and Heath met with claimant again on January 13, 1988 to discuss the relationship between claimant and Benniger. Claimant told them that the relationship had not improved, that she was not supervising Benniger and would continue to refuse to do so. Hickman talked with the other aides under claimant's supervision and learned that the rift between Benniger and claimant was adversely affecting the entire staff. Hickman also began to receive complaints from the day staff that the graveyard staff was not completing its assigned duties.

In view of the deficient performance of the graveyard staff, Hickman decided to observe and converse with the staff members during their shift to determine the nature and scope of

the problem. She spent four hours with the staff on February 9, 1988. Claimant was not on duty that night. During the shift, Hickman learned that some of the staff were sleeping during their breaks, that the staff was congregating in the break room during breaks and leaving a portion of the cottage unattended and that one aide was eating patients' food. All of these actions were against agency policy. Claimant was aware that the policy violations were occurring, but had never informed the staff of the policies or reprimanded them for the violations.

The day following her night at Holman Cottage, Hickman composed a memo detailing the problems she had discovered and met privately with claimant to discuss them. Claimant professed ignorance of the policy violations, but stated that she would talk to the staff about them.

About that time, Hickman also prepared revised position descriptions for the staff and gave them to claimant to distribute. She told claimant that the descriptions could require further revision and that it might be beneficial to discuss them with Chuck Farnham, the then Deputy Superintendent of Fairview Training Center. Claimant distributed the position descriptions to the staff, told them to sign them and said that if they did not, the descriptions would be revised and the matter would be brought to the attention of Chuck Farnham. Two of the staff members, Benniger and Nancy Moore, thought that claimant was threatening them and complained to Hickman. Hickman composed another memo on February 12, 1988 which stated that claimant's statements to the staff were "not necessary and not correct" and reprimanded her for making them.

On March 10, 1988, claimant and two staff members took a break together during the latter portion of their shift and left much of the cottage unattended. This was brought to Hickman's attention by the day shift supervisor, who had come to work early that morning. On March 16, 1988, Hickman composed a third memo which reprimanded claimant for the incident on March 10.

Claimant felt that she was being singled out by Hickman for disciplinary actions. About a year and a half before Hickman became her supervisor, claimant had reported a supervisory lapse of a close friend of Hickman to McClellan. Claimant believed that Hickman harbored a personal grudge against her for that reason and was trying to get back at her. Both of these perceptions were incorrect. Hickman did not have a grudge against claimant and did not single claimant out for disciplinary actions. Hickman reprimanded other shift supervisors for deficiencies similar to claimant's.

On March 22, 1988, Hickman and Heath met with claimant to discuss claimant's supervisory deficiencies. They told her that they were not satisfied with her performance and that they would like her to consider a demotion. They gave her two days to consider it.

On March 25, 1988, Heath met with claimant again and asked her what she had decided regarding a demotion. Claimant told him that she wanted to stay on as supervisor of Holman Cottage. Heath was not pleased with claimant's decision, raised his voice and told her that it was going to be difficult for her if she attempted to continue as supervisor.

The meeting between claimant and Heath occurred near the end of claimant's shift. Claimant was upset and crying after the meeting, went home and called Dr. Price, her family doctor. Price examined claimant on March 28, 1988 and recorded complaints of anxiety, depression and headaches. His examination also revealed elevated blood pressure. He diagnosed situational anxiety and depression, prescribed a tranquilizing medication and took her off work. Claimant filed a workers' compensation claim a few days later which was subsequently denied by SAIF.

On April 7, 1988, Dr. Price referred claimant to Dr. Gearheart, a psychiatrist. Gearheart diagnosed an "adjustment disorder with anxious mood." Claimant was examined by another psychiatrist, Dr. Turco, in June 1988.

FINDINGS OF ULTIMATE FACT

Claimant suffers from an adjustment disorder. This is a mental disorder generally recognized in the medical and psychological communities. The mental disorder required medical services and resulted in disability. Some of the events which caused claimant's mental disorder occurred on or after January 1, 1988.

Each of the disciplinary actions taken toward claimant by her supervisors was an employment condition which existed in a real and objective sense and was a material contributing cause of claimant's adjustment reaction. However, claimant's belief that those actions were improperly motivated and unfair was not justified by employment conditions which existed in a real and objective sense. All of the disciplinary actions taken toward claimant by her supervisors were reasonable.

CONCLUSIONS OF LAW

Applicability of the 1987 Amendments to ORS 656.802

In 1987, the Legislature amended ORS 656.802 by modifying the definition of an "occupational disease" and placing new restrictions on the compensability of stress-related mental disorders. Or Laws 1987, ch 713, § 4. These amendments became effective January 1, 1988. Id., § 8. The Referee concluded that the amendments were applicable in the present case. We agree.

In the absence of clear legislative intent to the contrary, an amendment to a workers' compensation statute which impairs existing rights or creates new obligations with respect to past transactions will not be applied retroactively. See ORS 656.202(2); Bradley v. SAIF, 38 Or App 559, 564, rev den 287 Or 123 (1979). The date of "injury" for purposes of determining the applicability of a statutory amendment affecting the compensability of an occupational disease is the date upon which the claimant was last exposed to the employment conditions which caused the disease. Johnson v. SAIF, 78 Or App 143, 146-48, rev den 301 Or 240 (1986).

The 1987 amendments to ORS 656.802 restrict the compensability of stress-induced mental disorders and thus impair rights which existed before the effective date of the amendments. There is no indication in the legislative history that the amendments were intended to have retroactive effect. The amendments, therefore, apply only to "injuries" occurring on or after January 1, 1988, the effective date of the amendments.

In the present case, a number of events which contributed to the cause of claimant's adjustment disorder occurred on or after January 1, 1988. Under the rule of Johnson v. SAIF, supra, therefore, the compensability of claimant's condition must be determined under the 1987 amendments to ORS 656.802.

Compensability

As amended in 1987, ORS 656.802(1) defines an "occupational disease" as:

> "(a) Any disease or infection arising out of and in the course of employment caused by ingestion of, absorption of, inhalation of or contact with dust, fumes, vapors, gasses, radiation or other conditions or substances to which an employe is not ordinarily subjected or exposed other than during a period of regular actual employment therein, and which requires medical services or results in disability or death.
>
> "(b) Any mental disorder arising out of and in the course of employment and which requires medical services or results in physical or mental disability or death.
> "(c) Any series of traumatic events or occurrences arising out of and in the course of employment which requires medical services or results in physical disabilty or death."

A new subsection (2) was also added to ORS 656.802 in 1987. It provides:

> "(2) Notwithstanding any other provision of this chapter, a mental disorder is not compensable under this chapter:
>
> "(a) Unless the employment conditions producing the mental disorder exist in a real and objective sense.
>
> "(b) Unless the employment conditions producing the mental disorder are conditions other than conditions generally inherent in every working situation or reasonable disciplinary, corrective or job performance evaluation actions, or cessation of employment.
>
> "(c) Unless there is a diagnosis of a mental or emotional disorder which is generally recognized in the medical or psychological community.
>
> "(d) Unless there is clear and convincing evidence that the mental disorder arose out of and in the course of employment."

Accordingly, pursuant to current ORS 656.802(2)(a), only

employment conditions which exist in a "real and objective sense" are considered in assessing the compensability of a claim for a mental disorder. In this regard, the Referee found that claimant's mental disorder was caused in material part by real and objective employment-related stressors. However, the Referee also concluded that the major cause of claimant's mental disorder was a belief unsupported by real and objective events. Consequently, the Referee was required to decide whether proof of a material work-related contribution was sufficient to establish compensability, or, instead, whether claimant must prove that real and objective employment-related stressors were the major cause of the onset of her mental disorder.

The rule under the prior law was clear. In Dethlefs v. Hyster Co., 295 Or 298 (1983), the Court interpreted former ORS 656.802(1)(a) to require that employment conditions be the major cause of an occupational disease. In reaching this conclusion, the Court relied upon language in the former statute that required that the disease or infection be one "*** to which an employee is not ordinarily subjected or exposed other than during a period of regular actual employment ***."

However, the language relied upon by the Court in Dethlefs was not retained in current ORS 656.802(1)(b) or (c). The Referee concluded that, under current ORS 656.802(1)(b), employment conditions need only be a material contributing cause of a mental disorder in order to support compensability. We agree.

In Donna E. Aschbacher, 41 Van Natta 1242 (Issued this date), we addressed a "repetitive trauma" claim made under current ORS 656.802(1)(c). We concluded that an injured worker need prove that her work exposure was a material, rather than major, cause of her condition in order to establish a compensable claim under that subsection. Moreover, as noted in Aschbacher, the analysis we applied to repetitive trauma claims under ORS 656.802(1)(c) is equally applicable to claims for mental disorders made under ORS 656.802(1)(b). We, therefore, conclude that, in order to establish a compensable mental disorder, an injured worker need prove, albeit by clear and convincing evidence, that work-related stressors not otherwise excluded under ORS 656.802(2) are a material, rather than major, cause of the disorder. We incorporate our discussion in Aschbacher with regard to this issue.

Pursuant to ORS 656.802(2)(b), the Referee noted a potential issue as to which party has the burden of proof to establish that the real stressors which materially contributed to claimant's mental disorder either were or were not "*** reasonable disciplinary, corrective or job performance evaluation actions by the employer ***." However, the Referee concluded that he need not decide this issue because, regardless of who had the burden on this issue, the evidence established that the corrective action taken by the employer was reasonable. Because we agree with the Referee's assessment of the evidence, we too decline to address the underlying burden of proof question.

Subject to the foregoing supplementation, we adopt the Referee's conclusions of law and agree with the Referee that claimant has failed to prove a compensable mental disorder.

ORDER

The Referee's order dated December 9, 1988 is affirmed.

Board Member Ferris, concurring in the result:

I concur in the majority's conclusions that the 1987 amendments to ORS 656.802 are applicable to this case and that claimant's claim is not compensable under those amendments. I write separately to express my disagreement with the majority's conclusion that a claimant who claims an occupational disease under ORS 656.802(1)(b) need only prove that work activity or exposure was a "material contributing cause" of the claimed condition. The reasons for my disagreement with the majority on this point are explained in my dissent in Donna E. Aschbacher, 41 Van Natta 1242 (WCB Case No. 88-07257; Issued this Date).

LUELLA A. KILMER, Claimant
McNutt & Thrush, Claimant's Attorneys
David Lillig (SAIF), Defense Attorney

WCB 89-01216
July 13, 1989
Order Denying Motion to Abate Referee's Order

The SAIF Corporation has requested "partial abatement" of a Referee's order which awarded claimant 13 percent (41.6 degrees) unscheduled permanent disability. Specifically, SAIF objects to that portion of the Referee's award which requires it to pay 5 percent unscheduled permanent disability for "pain." SAIF contends that a separate award for pain is improper.

The Referee's order issued on May 26, 1989. On June 16, 1989, SAIF filed a Request for Board Review of the Referee's order. Subsequently, on June 26, 1989, SAIF filed its Request for Partial Abatement of the Referee's order. This request was directed to the Referee. However, as a result of SAIF's prior request for Board review, the Referee no longer had jurisdiction to consider the request. See OAR 438-07-025; Michael A. Newell, 39 Van Natta 385 (1987); Eduardo Ybarra, 35 Van Natta 1192 (1983). Consequently, we consider SAIF's request as a Motion to Abate the Referee's Order directed to the Board. As such, we deny the motion.

SAIF's request is contrary to law. ORS 656.313(1) expressly states that the filing of an insurer's request for review shall not stay payment of compensation to a claimant. See Harold D. Tallent, 39 Van Natta 345 (1987); Robert E. Keys, 39 Van Natta 1132 (1987).

Accordingly, the motion is denied.

IT IS SO ORDERED.

DOROTHA L. McDARMENT, Claimant
Malagon & Moore, Claimant's Attorneys
Rick Barber (SAIF), Defense Attorney

WCB 86-09858
July 13, 1989
Order on Review

Claimant requested reconsideration of that portion of our February 23, 1989 Order on Review which found that claimant was not entitled to temporary disability benefits from October 28, 1986 through February 10, 1987 and declined to assess penalties and related attorney fee for nonpayment of the aforementioned temporary disability benefits. In order to fully consider the

matter, we abated our prior order and granted the SAIF Corporation ten days in which to respond. After receiving SAIF's response, and further considering the matter, we make the following conclusions.

Claimant contends that we erred in finding that SAIF had not received medical verification of claimant's inability to work until the date of surgery. We disagree.

In October 1986, Dr. Carlsen recommended surgery. On December 22, 1986, SAIF wrote Dr. Carlsen, noting that the surgery would be authorized, and asking whether he was authorizing time loss prior to surgery. SAIF further asked if claimant was able to perform bookkeeping duties prior to the surgery. On December 26, 1987, Dr. Carlsen wrote SAIF indicating that there was no reason claimant could not perform bookkeeping duties prior to surgery, as those duties were of a sedentary nature. Dr. Carlsen did not refer to time loss authorization.

On January 23, 1987, claimant's counsel wrote Dr. Carlsen asking if he would agree that claimant was unable to perform her usual duties of work as of the date surgery was recommended. The term usual was not defined. (Emphasis added). On January 27, 1987, Dr. Carlsen signed the letter from claimant's counsel apparently indicating agreement. This letter was received by SAIF on February 3, 1987. Claimant's surgery was performed February 11, 1987, and SAIF began paying time loss benefits as of that date. On February 26, 1987, Dr. Carlsen wrote SAIF reiterating that claimant could perform bookkeeping or sedentary duties prior to the date of surgery.

Entitlement to interim compensation in the form of temporary total disability depends on whether, before the denial of an aggravation claim, there was a medical verification of a claimant's inability to work. ORS 656.273(6); Berkey v. Fairview Hospital, 94 Or App 28, 31 (1988). If the employer has notice or knowledge of verification, temporary total disability payments must begin within 14 days. ORS 656.273(6). The notification is not intended to establish a substantive right to compensability, but is intended to ensure prompt payment of interim support to a worker who has filed an aggravation claim. Silsby v. SAIF, 39 Or App 555, 562 (1979).

In our Order on Review, we agreed with the Referee's finding that claimant's regular work in 1986 was helping to run a family-operated gas station, including the performance of bookkeeping duties. On December 26, 1987, and February 23, 1987, Dr. Carlsen indicated that claimant could perform bookkeeping or sedentary work prior to surgery. The only contrary statement is Dr. Carlsen's signature on claimant's counsel's January 23, 1987 letter indicating that claimant was unable to perform her usual duties as of the date surgery was recommended.

Under these circumstances, we maintain our conclusion that the January 23, 1987 letter does not constitute medical verification of inability to work. In light of Dr. Carlsen's letters of December 26 and January 8, which specifically refer to an ability to perform bookkeeping or sedentary work, we do not read his signature on a letter from claimant's counsel indicating that claimant could not perform her usual work after October 28, 1986, to be an authorization of time off work. Accordingly, claimant is neither procedurally entitled to temporary disability

benefits pursuant to ORS 656.273(6) nor substantively entitled to temporary disability compensation between October 28, 1986 and February 11, 1987.

On reconsideration, as supplemented herein, we adhere to and republish our former order, effective this date.

IT IS SO ORDERED.

LEONARD TRIGG, Claimant
Douglas D. Hagen, Claimant's Attorney
Schwabe, et al., Defense Attorneys

WCB 87-02800 & 86-15419
July 13, 1989
Order on Review

Reviewed by Board Members Crider and Johnson.

Claimant requests review of those portions of Referee Lipton's order which: (1) upheld the self-insured employer's May 27, 1986 denial of his left knee injury claim; and (2) declined to assess a penalty and attorney fee for the alleged unreasonable denial. In its brief, the self-insured employer contends that the Referee erred in finding "good cause" for claimant's untimely filing of his request for hearing. We agree and reverse.

ISSUES

1. Whether claimant had good cause for untimely filing his hearing request.
2. If so, whether claimant's left knee injury claim is compensable.
3. If so, whether a penalty and attorney fee should be assessed for the employer's allegedly unreasonable denial.

We reverse on the timeliness issue, thus mooting the remaining issues.

FINDINGS OF FACT

Timeliness of Hearing Request

Claimant filed a claim for a left knee injury in April, 1986. It was denied on May 27, 1986. Claimant received the denial letter on May 29, 1986, and read its content, including the paragraph regarding his appeal rights. He phoned Alexsis Risk Management, the employer's claims administrator, and learned that it had not received a medical report from Dr. Rusch, his long-time treating orthopedist. He contacted Rusch's office and was told that a report would be sent. He subsequently called Alexsis several times and was told that the report had not yet been received.

On or about June 17, 1986, claimant went to Alexsis's office and spoke to the claims manager, Ms. Robertson. Robertson told him that Rusch's report had not arrived but that she would try to obtain it. Claimant assumed that, when the report was obtained, everything would be "okay" or he would be advised otherwise. He was never told, however, that his claim would be accepted upon receipt of the report or that he should not appeal the denial.

On or about July 1, 1986, claimant received unspecified claims documents from the employer's counsel. He reviewed them and put them away for safekeeping. In October, 1986, claimant approached Robertson after an employe meeting and inquired into the status of his claim. After that conversation, claimant secured counsel and filed

his hearing request from the denial on November 5, 1986, just over five months after issuance of the denial.

FINDINGS OF ULTIMATE FACT

Claimant's hearing request was not filed within 60 days of the denial. He did not have good cause for the delay in filing the request.

CONCLUSIONS OF LAW AND OPINION

Timeliness of Hearing Request

The Referee found that, although claimant did not file a timely hearing request, he had good cause for failing to do so. Specifically, the Referee found that claimant had demonstrated "excusable neglect" based on both his reliance on Alexsis's promise to obtain a report from Dr. Rusch and his past claims experience with the employer. We disagree.

It is undisputed that claimant's hearing request was not timely filed. That delay may nevertheless be excused if claimant had good cause for the late filing. See ORS 656.319(1)(b). The test for determining if good cause exists has been equated to the standard of "mistake, inadvertance, surprise or excusable neglect" recognized under ORCP 71B(1) and former ORS 18.160. Anderson v. Publishers Paper Co., 78 Or App 513, 517, rev den 301 Or 666 (1986); see also Brown v. EBI Companies, 289 Or 455 (1980). Lack of diligence does not constitute good cause. Cogswell v. SAIF, 74 Or App 234, 237 (1985). Claimant has the burden of proving good cause. Id.

One of the cases decided under former ORS 18.160 -- Rogue Val. Mem. Hosp. v. Salem Ins., 265 Or 603 (1973) -- is analogous here. There, the Court was faced with the question of whether the defendant's neglect in failing to respond to a summons and complaint was sufficiently excusable to support a motion to vacate the resulting default judgment. The defendant was personally served with the summons and complaint in an action brought against co-defendant insurance company and defendant as agent of that company. Defendant forwarded the documents to the insurance company and did nothing further, relying, instead, on the insurance company to take care of the matter. The Court held that defendant failed to establish excusable neglect, noting the following persuasive factors: (1) the insurance company gave defendant no assurance that it would do what was necessary to protect his interest; (2) the summons included notice that defendant was required to appear or the other party would win automatically; and (3) defendant offered no explanation for a delay of nearly two months after he learned that a default judgment had been entered against him until he consulted an attorney.

Here, claimant felt assured that the employer's claims administrator would obtain a medical report from his doctor. Like Rogue Val. Mem. Hosp. v. Salem Ins., however, there is no evidence that the administrator ever assured claimant that his interest would be protected. No one told him that the denial would be reconsidered, much less overturned, upon receipt of the report or that he should not appeal the denial. Hence, claimant had no reasonable basis for believing that he did not have to appeal the denial. Furthermore, the denial letter contained a prominent description of his appeal rights, as well as the limitations on those rights. Yet, claimant failed to avail himself of those rights. Claimant explains that, because he did

not have difficulties with a previous claim for his right knee, he assumed that this claim would be similarly resolved without resort to the legal system. That assumption will not support a finding of excusable neglect. Past claims experience alone does not relieve claimant of his responsibility to pursue his claim with due diligence; nor does it amount to "excusable neglect". We find no event or occurrence which could have interfered with the relatively simple task of timely filing a hearing request. Claimant's lack of diligence does not constitute good cause. See Cogswell v. SAIF, 74 Or App 234, 237 (1985). Accordingly, claimant's hearing request is dismissed. See ORS 656.319(1)(b).

Compensability and Penalties and Attorney Fees

We have found above that claimant did not prove good cause to excuse his late hearing request. Therefore, the issues of compensability and penalties and attorney fees are moot. We do not address these issues.

ORDER

The Referee's order dated June 16, 1987 is reversed. Claimant's hearing request, filed on November 5, 1986, is dismissed. The Board approves a client-paid fee not to exceed $337.50.

LARRY VIGAL, Claimant
Brian R. Whitehead, Claimant's Attorney
Gary Wallmark (SAIF), Defense Attorney

WCB 88-20066
July 13, 1989
Order Denying Motion to Dismiss

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

FINDINGS

The Referee's Opinion and Order issued April 13, 1989. On April 17, 1989, SAIF asked the Referee to amend the order. On May 3, 1989, the Referee issued an Amended Opinion and Order. In so doing, the Referee withdrew the April 13, 1989 order and republished it with supplementation.

On May 8, 1989, SAIF mailed a request for review of the "Referee's Opinion and Order made and entered on April 13, 1989" to the Board. The request, which was mailed by certified mail, included a certificate of personal service by mail upon claimant and his attorney.

ULTIMATE FINDINGS

The Referee's April 13, 1989 order was withdrawn and republished, as supplemented, by the Referee's May 3, 1989 amended order. SAIF's request for review was mailed to the Board within 30 days from the Referee's orders.

CONCLUSIONS

A Referee's order is final unless, within 30 days after the date on which a copy of the order is mailed to the parties, one of the parties requests Board review under ORS 656.295. ORS 656.289(3). The time within which to appeal an order continues to

run, unless the order has been stayed, withdrawn, or modified. International Paper Company v. Wright, 80 Or App 444 (1986); Fischer v. SAIF, 76 Or App 656 (1985). 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 April 13, 1989 order was expressly withdrawn by the Referee's May 3, 1989 order. Yet, upon the issuance of the May 3, 1989 order, the April 13, 1989 order was republished and supplemented. Since SAIF requested Board review within 30 days of the May 3, 1989 order, we conclude that we retain jurisdiction to consider this matter.

Admittedly, SAIF requested Board review of the Referee's "April 13, 1989" order. However, SAIF's intention was both clear and unambiguous. It was appealing the Referee's decision in WCB Case No. 88-20066. Inasmuch as SAIF's request reflected its desire to appeal, as an aggrieved party, a specific Referee's order and because that order had been withdrawn, republished and supplemented prior to the filing of the request for review, we consider the request as one for review of the Referee's subsequent decision.

Accordingly, the motion to dismiss is denied. Assuming that it has received a copy of an entire transcript, SAIF's appellant's brief shall be due 14 days from the date of this order. Claimant's respondent's brief shall be due 14 days from the date of mailing of SAIF's appellant's brief. SAIF's reply shall be due 7 days from the date of mailing of claimant's respondent's brief. Thereafter, this case will be docketed for review.

IT IS SO ORDERED.

VICTOR J. PADILLA, Claimant
Galton, et al., Claimant's Attorneys
Chelsea Mohnike (SAIF), Defense Attorney

WCB 87-11755
April 7, 1989
Order on Review

Reviewed by Board Members Ferris and Crider.

Claimant requests review of those portions of Referee Knapp's order that upheld the SAIF Corporation's denial of his aggravation claim for a lumbar condition. Claimant also requests that the Board assess penalties and attorney fees agreed to by the parties, which the Referee failed to memorialize in his order. On review, the issues are aggravation and penalties and attorney fees.

We affirm the Referee on the aggravation issue and assess the requested penalty and attorney fee.

FINDINGS OF FACT

We adopt the Referee's findings of fact, except that we find that Dr. Gibbon issued a report on claimant's condition on August 10, 1987, rather than April 10, 1987.

We make the following additional findings.

Claimant had experienced the following symptoms prior to his compensable injury in May 1986: left calf pain, numbness, weakness, wasting and hair loss; numbness and tingling in the left foot; and numbness, warmness and loss of control in the left ankle.

Claimant experienced an exacerbation of left hip and left leg and foot symptoms following his May 1986 injury. His condition had returned to its pre-injury status by late summer 1986. In or around October 1986, he began experiencing more frequent and more intense symptomatic flare-ups. X-rays taken in November 1986 revealed L4-5 degenerative disc disease and loss of L4-5 disc space. By December 1986, his condition was so severe that he was unable to work cutting Christmas trees.

Claimant requested a hearing on the February 11, 1987 and March 4, 1987 Determination Orders.

In late August 1987, claimant filed an aggravation claim for time loss and medical treatment related to his lumbar and cervical spine problems. In November 1987, SAIF denied the claim on the ground that claimant's current neck and low back condition was not causally related to his prior compensable injury. Claimant subsequently amended his hearing request to include this denial.

Prior to hearing, claimant and SAIF agreed to resolve all penalty and related attorney fee issues with SAIF's payment of a $375 penalty and a $375 attorney fee.

FINDINGS OF ULTIMATE FACT

Claimant has not established that his current low back condition is causally related to his prior compensable injury.

CONCLUSIONS OF LAW AND OPINION

Penalties and Attorney Fees

The Referee failed to award a $375 penalty, and an attorney fee in the same amount, as agreed to by the parties prior to hearing. On review, claimant and SAIF both agree that claimant is entitled to the stipulated penalty and attorney fee. We, therefore, modify the Referee's order to include an award of a penalty and attorney fee in the agreed upon amount.

Aggravation

We adopt the Referee's opinion on this issue, subject to the following comment.

The Referee concluded that claimant had not demonstrated that his current lumbar condition was causally related to his compensable injury. In reaching his decision, the Referee deferred to the opinion of orthopedic surgeon Stewart and neurologist Snodgrass. Drs. Stewart and Snodgrass participated in an independent medical examination in December 1987. Based on that examination, they opined that claimant's current lumbar symptoms were attributable to the natural progression of his preexisting back condition. The Referee discounted the contrary opinions of the consulting neurologist, Dr. Kim, and the treating chiropractor, Dr. Gibbon. These doctors took the position that

claimant's current lumbar condition was related to his May 1986 injury.

The Referee discounted Dr. Kim's opinion because it was based on an incomplete history of claimant's prior back and leg problems. We agree. Dr. Kim alluded to the fact that claimant had experienced "back pain" prior to his May 1986 accident. However, there is nothing in the record to suggest that Dr. Kim had been apprised of the full extent of claimant's prior symptoms. Nor is it clear that Dr. Kim knew that claimant's post-injury symptoms resolved in the summer of 1986, or that his chronic condition did not worsen until October of that year. Dr. Kim could not have rendered a well-reasoned opinion without this information.

We also agree that Dr. Gibbon's opinion is not persuasive. He is a chiropractor without special training in neurology or orthopedics. By comparison, neurologist Snodgrass and orthopedic surgeon Stewart have special expertise in diagnosing and treating spinal conditions. The Referee correctly deferred to their opinion.

ORDER

The Referee's order dated February 11, 1988 is affirmed in part and modified in part. Claimant is awarded a $375 penalty and a $375 attorney fee, to be paid by the SAIF Corporation. The remainder of the Referee's order is affirmed.

HERMAN LOVAN, Claimant
Emmons, et al., Claimant's Attorneys
SAIF Corp Legal, Defense Attorney

Own Motion 87-0546M
July 18, 1989
Own Motion Determination

The Board issued an Own Motion Order in the above-entitled matter on September 30, 1987 reopening claimant's claim for worsened conditions related to his industrial injury of November 17, 1959. The claim has now been submitted for closure. We grant claimant additional awards of temporary total disability and permanent total disability.

ISSUES

1. Temporary total disability.
2. Permanent total disability.

FINDINGS OF FACT

Claimant sustained compensable fractures to the right hip and the L3 vertebral disc in a logging accident on November 17, 1959. The hip fracture was surgically repaired by open reduction and internal fixation. His injury claim was closed by Determination Order on April 27, 1962, with 20 percent scheduled permanent disability for the loss of function of the right leg and 30 percent "loss of function of an arm for unscheduled [permanent] disability." The latter 30-percent award apparently compensated claimant for unscheduled disability arising from the back injury.

In August, 1987, claimant sought treatment for back and hip pain. X-rays revealed degenerative arthritic changes occurring in the lumbar spine and right hip joint. A total hip replacement was recommended. By Own Motion Order of September 30, 1987, as amended on October 19, 1987, the Board reopened

claimant's injury claim for payment of medical services for the hip and temporary disability benefits commencing on the date of the total hip procedure and continuing until closure. The total hip arthroplasty was performed on November 3, 1987. Claimant did not return to work after surgery. Claimant's right hip condition became medically stationary on June 28, 1988.

In June, 1988, claimant sought treatment for low back symptoms. On Sepember 9, 1988, the Board issued a Supplemental Own Motion Order, finding that the current low back condition was related to the 1959 injury and, therefore, directing SAIF to pay for low back treatment. The Board further directed that closure of claimant's claim would be postponed until the low back condition had become medically stationary. Claimant's low back condition became medically stationary on September 29, 1988.

Claimant is 56 years of age with a sixth grade education. Due to the compensable injury, claimant has permanent limitations on standing, prolonged sitting, walking, driving, bending, twisting and any work on uneven ground. He can perform sedentary to light work, occasionally lifting over 35 pounds. He must be able to change positions as needed. Claimant is unable to perform his previous job. We do not find that he has transferable skills to light or sedentary work.

ULTIMATE FINDING OF FACT

Due to physical limitations resulting from the compensable injury, as well as nonmedical factors such as claimant's advanced age, limited education and work experience, claimant is unable to perform any work at a gainful and suitable occupation.

CONCLUSIONS OF LAW AND OPINION

The date of reopening of claimant's injury claim preceded the effective date of the current own motion law; hence, this case is governed by former ORS 656.278 and the rules promulgated thereunder. OAR 438-12-018. Under former ORS 656.278, the Board may modify prior awards of compensation, including temporary and permanent disability.

Temporary Total Disability

Temporary total disability compensation is designed to compensate claimant for loss of income due to a compensable injury until claimant's condition becomes medically stationary. Taylor v. SAIF, 40 Or App 437, 440, rev den 287 Or 477 (1979). Here, the medical evidence establishes that claimant became medically stationary regarding his hip and back conditions on September 29, 1988. Accordingly, claimant's claim is closed with an award of temporary total disability from November 3, 1987, through September 29, 1988.

Permanent Total Disability

To establish his entitlement to permanent total disability (PTD), claimant must prove that he is unable to perform any work at a gainful and suitable occupation. ORS 656.206(1)(a); Harris v. SAIF, 292 Or 683, 695 (1982). The determination of PTD status turns upon whether claimant is currently employable or able to sell his services on a regular basis in a hypothetically normal

labor market. Harris v. SAIF, supra. Dr. Lumsden, claimant's family physician, opined that claimant is permanently disabled from all occupations based on his age, education and physical limitations. Lumsden's consideration of nonmedical factors such as age and education suggests that he would not find claimant unemployable based on his physical limitations alone. That suggestion is supported by the independent medical examination report by Drs. Henson and Taylor, neurologists. They concluded that claimant can return to light or sedentary work without heavy lifting or repetitive bending. Based on those reports, we find that claimant has the physical capacity to perform light or sedentary work.

Nevertheless, claimant can still establish PTD by proving that he falls within the so-called "odd-lot" doctrine. Under that doctrine, an injured worker, capable of performing work of some kind, may still be permanently and totally disabled due to a combination of his physical condition and certain nonmedical factors, such as age, education, work experience, adaptability to nonphysical labor, mental capacity and emotional conditions. Clark v. Boise Cascade Corp., 72 Or App 397, 399 (1985). Here, there is no reliable vocational evidence that claimant has the transferable skills necessary to perform light or sedentary work. Although there is evidence that claimant has prior work experience in logging, trucking and law enforcement, there is no evidence that claimant can still perform those vocations. Indeed, claimant's physical restrictions from heavy lifting and prolonged sitting or driving would appear to preclude him from logging and trucking. After reviewing the available evidence regarding medical and nonmedical factors, we find that claimant is unable to perform any work at a gainful and suitable occupation. Accordingly, he is entitled to an award of permanent total disability.

IT IS SO ORDERED.

JOSE E. SARAIVA, Claimant
Welch, Bruun & Green, Claimant's Attorneys
Mitchell, Lang & Smith, Defense Attorneys

WCB 89-02232
July 18, 1989
Order Dismissing Request for Board Review (Remanding)

Claimant has requested Board review of Referee Quillinan's order, dated May 15, 1989, that denied Crawford and Company's ("Crawford's") motion to join American International Adjustment Co. ("AIAC") as a party defendant to a then forthcoming hearing. Crawford has cross-requested Board review. We have reviewed the requests solely to determine whether the Referee's order is a final order, which is subject to Board review. Joseph Wilson, 40 Van Natta 66 (1988). We conclude that the Referee's order is not a final order and that we, therefore, lack jurisdiction to consider the requests.

FINDINGS

On April 6, 1989, Crawford moved for joinder of AIAC, as a necessary party to a then forthcoming hearing concerning, inter alia, an alleged aggravation of claimant's compensable November, 1985, low back injury. By way of an Order Denying Joinder, dated May 15, 1989, Referee Quillinan denied the motion. On June 12, 1989, claimant requested Board review of the Referee's order. Crawford cross-requested review on June 15, 1989.

ULTIMATE FINDINGS OF FACT

The Referee's order did not finally deny or allow the claim, nor did it fix the amount of claimant's compensation.

CONCLUSIONS OF LAW

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 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 declined to join a potentially responsible insurer as a necessary party to a future hearing.

Inasmuch as further action before the Hearings Division is required as a result of the Referee's order, we conclude that it is not a final appealable order. Price v. SAIF, supra; Lindamood v. SAIF, supra; William L. Miller, 39 Van Natta 1020 (1987). Consequently, we do not consider the issues raised by the requests for Board review.

Accordingly, the requests for Board review are dismissed and this matter is remanded to Referee Quillinan for further proceedings.

IT IS SO ORDERED.

RENE VAN WOESIK, Claimant
Peter O. Hansen, Claimant's Attorney
Roberts, et al., Defense Attorneys

WCB 84-09431
July 18, 1989
Order on Reconsideration

Claimant's co-counsel, Peter O. Hansen, seeks Board authorization of an assessed fee for services performed at hearing, on Board review, and on judicial review, which culminated in our June 23, 1989, Order on Remand.

After review of the statement of services and attorney retainer agreement submitted by claimant's co-counsel, we decline to authorize an assessed fee.

At the hearing and on Board review, claimant was represented by Mr. Hansen. The primary issue in those proceedings was whether or not claimant had sustained an aggravation of his compensable 1980 low back injury. Both the Referee and the Board found against claimant. On judicial review, claimant was represented by attorney James L. Edmunson, of Malagon, Moore & Johnson, as well as Mr. Hansen. Mr. Edmunson filed claimant's Appellant's Brief and, apparently, presented oral argument before the court on claimant's behalf.

The court found for claimant and reversed and remanded to the Board. In its Appellant's Judgment, the court awarded: "attorney fees payable to James L. Edmunson, of Malagon, Moore & Johnson, in the amount of $4,243.75, in addition to and not out of

compensation due claimant." See ORS 656.386(1). The court further noted in its Judgment that Mr. Hansen had "filed an association of counsel."

In our view, the court has already awarded claimant's counsel, whether Mr. Edmunson or Mr. Hansen, the appropriate assessed attorney fee for services throughout the various stages of litigation and appeal. Mr. Hansen's status as "associate counsel" does not, in our view, entitle him to a separate assessed fee in addition to the fee already awarded by the court.

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

IT IS SO ORDERED.

MICHAEL A. GRIGGS, Claimant
Roll, et al., Claimant's Attorneys
Roberts, et al., Defense Attorneys
Roy Miller (SAIF), Defense Attorney
Stafford Hazelett, Defense Attorney

WCB 88-04104, 88-03394 & 88-03395
July 19, 1989
Order on Review

Reviewed by Board Members Ferris & Johnson

Liberty Northwest Insurance Corporation requests Board review of Referee Peterson's order that: (1) set aside its denial of claimant's "new injury" claim for a low back condition; (2) upheld Cigna Insurance Companies' denial of claimant's "new injury" claim for the same condition; and (3) upheld the SAIF Corporation's denial of claimant's aggravation claim for the same condition. Claimant filed a cross-request for review, but, in his brief, seeks affirmance of the Referee's order.

Liberty Northwest has advised the Board that it has withdrawn its request for review. However, in the event that we find another insurer responsible for the claim, Liberty Northwest seeks reimbursement for its claim costs. The other insurers object to Liberty Northwest's reimbursement request, as well as an Order on Reconsideration Approving Settlement between Liberty Northwest and claimant in WCB Case Nos. 88-17500 & 89-00832.

We affirm and adopt the Referee's order. Consequently, the request for reimbursement is moot. Furthermore, we offer no comment concerning the validity of the Referee's order in WCB Case Nos. 88-17500 & 89-00832.

Finally, Liberty Northwest requested Board review and, despite the announced withdrawal of its request, continued to, in essence, shift responsibility for claimant's claim by seeking reimbursement of its claim costs. Since no order designating a paying agent pursuant to ORS 656.307 had issued, claimant's entitlement to compensation remained at risk. See Thomas W. Williamson, 39 Van Natta 1147 (1987). Claimant's counsel participated on review and contended that the Referee's order should be affirmed. Under such circumstances, claimant's attorney is entitled to a fee for services on review under ORS 656.382(2), payable by Liberty Northwest, the insurer who initiated Board review. Larry J. Salee, 41 Van Natta 269 (1989).

ORDER

The Referee's order dated May 25, 1988 is affirmed. A client-paid fee, payable from Cigna to its counsel, is approved, not to exceed $1,300. For services on review concerning the compensability issue, claimant's attorney is awarded a reasonable fee of $250, to be paid by Liberty Northwest.

DARLENE B. LITFIN, Claimant
Lovejoy & Green, Claimant's Attorneys
SAIF Corp, Insurance Carrier

Own Motion 88-0698M
July 19, 1989
Own Motion Determination

Claimant has requested that the Board exercise its "Own Motion" authority and reopen her 1981 injury claim with the SAIF Corporation for an alleged worsening of her low back condition. Claimant requests reopening for both medical services and temporary disability compensation. Her aggravation rights have expired. SAIF contends that the claim does not qualify for reopening under the Board's "Own Motion" authority. We agree.

We process claimant's request under the current version of ORS 656.278. See OAR-438-12-018. We first address her request for additional medical services. Our "Own Motion" authority to reopen a claim for medical benefits is limited to pre-1966 injuries. ORS 656.278(1)(b). For later injuries, the Hearings Division has continuing jurisdiction over medical services claims for the life of the claimant. ORS 656.245. Accordingly, we are without authority to authorize medical benefits for claimant's 1981 injury. However, she has the right to file a hearing request on this issue, provided the statutory filing period has not run. See ORS 656.319.

We turn to claimant's request for additional temporary disability benefits. Our "Own Motion" authority to award such benefits is limited to situations where a worsened condition requires inpatient or outpatient surgery, or other treatment requiring hospitalization. ORS 656.278(1)(a). Furthermore, the worsening must have occurred after the expiration of the statutory aggravation period. If the worsening occurs within the aggravation period, the Hearings Division retains jurisdiction over related temporary disability claims. ORS 656.273. Here, claimant's aggravation rights expired on June 17, 1988, and the record indicates that her condition last required hospitalization in April 1988. Accordingly, we are unable to reopen her claim and award the requested temporary disability compensation.

However, claimant has the right to file a hearing request regarding any worsening of her condition during the aggravation period, provided the statutory filing period has not run. See ORS 656.319. On January 12, 1988, SAIF formally denied claimant's aggravation claim, contending that her condition had not worsened since the last arrangement of compensation. Claimant apparently did not file a timely hearing request regarding this denial. However, it appears that she may have filed new aggravation claims in April and May 1988, based on her current condition. If such claims were submitted and remain in "de facto" denied status, the period for requesting a hearing has not begun to run and claimant may seek reopening of her claim in the Hearings Division.

IT IS SO ORDERED.

LOUISE BETTS COURY, Claimant
LENA M. SPALITTA, dba,
MR. & MRS. HAIR DESIGN & BEAUTY Products, Emp.
Carney, Buckley, et al., Claimant's Attorneys
Richard C. Pearce, Attorney
SAIF Corp Legal, Defense Attorney

WCB 87-05458 & 87-05459
July 27, 1989
Order on Reconsideration

Reviewed by Board Members Crider and Ferris.

The noncomplying employer requests reconsideration of our June 29, 1989 order that affirmed a Referee's order which: (1) found that claimant suffered a compensable injury; and (2) declined to set aside the SAIF Corporation's acceptance of claimant's injury claim, issued on behalf of the noncomplying employer.

In reaching our decision, we reasoned that the employer's hearing request concerning SAIF's acceptance did not constitute a valid denial of the claim under ORS 656.262(8). Inasmuch as SAIF had properly accepted the claim and the employer had not properly denied it, we held that claimant was entitled to compensation. We relied upon Derryberry v. Dokey, 91 Or App 533 (1988), and Darrell E. Breymier, 40 Van Natta 1164 (1988). Finally, assuming arguendo that the compensability issue was properly before us, we agreed with the Referee's finding that claimant's injury was work-related.

The employer raises several objections to our order. Specifically, the employer requests reconsideration of our application of the Derryberry holding and the issue of compensability. In addition, the employer seeks permission to supplement the record to defend itself from the application of the Derryberry holding.

The request for reconsideration is granted and our prior order withdrawn. On reconsideration, we conclude that our prior adherence to the Derryberry holding was appropriate. Consequently, for the reasons expressed in our previous decision, we continue to conclude that the employer's denial was improper and that claimant is entitled to compensation. We further reiterate that, had we addressed the compensability issue, we would adopt the Referee's reasoning that the injury was compensable. Accordingly, as supplemented herein, we adhere to and republish our prior order, effective this date.

Finally, because our review is based upon the record submitted and since the employer seeks supplementation of that record, we consider the request as a motion to remand to the Referee for the taking of additional evidence. ORS 656.295(5). We may remand to the Referee should we find that the record has been "improperly, incompletely or otherwise insufficiently developed." id. To merit remand, it must be established that the evidence relevant to the issues raised in this request was unobtainable with due diligence before the hearing. See Bernard L. Osborn, 37 Van Natta 1054, 1055 (1985), aff'd mem 80 Or App 152 (1986).

Here, the basis for the employer's request could be advanced by any party disadvantaged by the application of an appellate decision rendered subsequent to an appealed Referee's order. Such grounds generally do not warrant remand. See James L. Lance, 39 Van Natta 1153 (1987), aff'd mem 92 Or App 591 (1988) (Counsel's action at hearing taken in reliance upon the Court of Appeals' decision in Runft v. SAIF, 78 Or App 356 (1986), did not constitute grounds for remand when Runft decision was subsequently

reversed by Supreme Court, 303 Or 493 (1987)); Richard L. White, 41 Van Natta 795, 904 (1989) (Motion to remand for the taking of additional evidence concerning temporary disability issue, prompted by a so-called "dramatic change in the law" in Fazzolari v. United Beer Distributors, 91 Or App 592, recon 93 Or App 103, rev den 307 Or 236 (1988), which had issued after the appeal of the Referee's order, was denied).

After considering the evidence concerning the Derryberry and compensability issues, we do not consider the record to have been improperly, incompletely or otherwise insufficiently developed. Furthermore, we are not persuaded that the "evidence" pertaining to these issues, which the employer has yet to identify, was unobtainable with due diligence before the hearing. Accordingly, the motion to remand for the taking of additional evidence is denied.

IT IS SO ORDERED.

HANLON DODGION, (Deceased), Claimant
Gerald Miller, Claimant's Attorney
James E. Griffin, Assistant Attorney General

WCB TP-87027
July 27, 1989
Third Party Distribution Order

Reviewed by Board Members Ferris and Johnson.

The SAIF Corporation, as paying agency, has petitioned the Board for an order declaring the validity of its lien in the proceeds of a third-party settlement and distributing those proceeds in accordance with ORS 656.593(3). The deceased worker's beneficiary contends that SAIF's lien is invalid because Michigan's no-fault motor vehicle insurance law precluded tort recovery from the third parties for the losses compensated by SAIF.

ISSUE

Whether the fact that the beneficiary's right of tort recovery was limited by Michigan law to certain categories of loss limits SAIF's right to share in the proceeds of the beneficiary's settlement with the third parties.

FINDINGS OF FACT

The deceased worker was killed on June 6, 1984 when a truck which he was driving collided head-on with another truck in the State of Michigan. The worker was a long haul truck driver for American Hardwoods, an Oregon employer covered by SAIF. At the time of the accident, he was en route from Timiskming Station, Quebec to Portland, Oregon by way of Seattle, Washington. The worker was a resident of Vancouver, Washington at the time of the accident. The beneficiary still resides there. The other truck involved in the accident was owned by Twin Ports Grocery Company of Duluth, Minnesota. The driver of the truck, Glen K. Samberg, was a resident of the State of Minnesota. Samberg also died in the accident.

The beneficiary filed a workers' compensation claim in connection with her husband's death which was accepted by SAIF. SAIF had paid a total of $31,568.93 in compensation at the time of its petition. The present value of its reasonably to be expected future payments for compensation is $136,561.90. SAIF thus claims a total lien of $168,130.83.

In March 1986, the beneficiary commenced a diversity action against the estate of Glen K. Samberg and Twin Ports Grocery Company in the United States District Court for the Western District of Michigan. In December 1987, the beneficiary entered into a settlement with the defendants whereby the beneficiary was paid a lump sum of $165,318.38. The last paragraph of the settlement agreement provides, "It is further agreed by the parties that all of the consideration paid to the the Plaintiff, Judith Ann Dodgion, as Personal Representative of the the Estate of Hanlon Dodgion, is consideration for non-economic loss. The parties agree that no portion of the settlement is consideration for economic loss." A short time prior to the date of the settlement, claimant's attorneys informed SAIF that they considered its lien to be invalid and that it would not be allowed to share in the settlement proceeds.

At the time of the accident, the third-party defendants were insured by a company with the written certification described in section 500.3163 of the Michigan Compiled Laws Annotated on file with the Michigan Department of Licensing.

CONCLUSIONS OF LAW

The beneficiary contends that the lien asserted by SAIF in the proceeds of her settlement with the third parties is invalid because Michigan's no-fault motor vehicle insurance law precluded tort recovery from the third parties for the losses compensated by SAIF. We dealt with this issue at length in another case arising out of the same motor vehicle accident which killed Mr. Dodgion. Marvin H. Allen, 41 Van Natta 1323 (1989). We concluded that in that case that the fact that the claimant's recovery was limited by Michigan law to certain categories of loss did not limit SAIF's right to share in the proceeds of the claimant's settlement with the third parties. The same rule applies in this case. SAIF's lien, therefore, attached to and may be satisfied out of all of the proceeds of the beneficiary's third-party settlement.

We further conclude that a distribution of proceeds from the settlement in accordance with ORS 656.593(1) would be "just and proper." See ORS 656.593(3); Robert L. Cavil, 39 Van Natta 721 (1987). Accordingly, claimant is directed to distribute the proceeds from the third party settlement in accordance with ORS 656.593(1).

IT IS SO ORDERED.

JAMES L. GUYTON, Claimant
Francesconi & Associates, Claimant's Attorneys
Shelly McIntyre (SAIF), Defense Attorney

WCB 88-12582
July 27, 1989
Order on Review

Reviewed by Board Members Crider and Ferris

Claimant requests review of Referee Quillinan's order that: (1) upheld the SAIF Corporation's denial, on behalf of Fuller's Restaurant ("Fuller's"), of claimant's claim for injury to his back, neck, head, left arm, shoulder, and right leg; (2) remanded the claim for acceptance and payment of benefits to SAIF as a purported processing agent for Albert Nelson ("Nelson"), an alleged noncomplying employer; and (3) declined to award an assessed attorney fee to claimant's counsel. On review, claimant argues that he was an employee of Fuller's at the time of the injury. Alternatively, claimant requests that we remand in order to join Nelson as a party. SAIF argues that the Referee lacked

jurisdiction to order it to accept and process the claim on behalf of Nelson. We decline to remand. On the merits, we affirm in part and vacate in part.

ISSUES

1. Remand.

2. Jurisdiction.

3. Compensability.

4. Attorney fees.

FINDINGS OF FACT

The Board adopts the Referee's Findings of Fact with the following supplementation.

All equipment used to perform demolition work was provided by Nelson.

The claim was set for hearing on October 13, 1988. On September 30, 1988, SAIF filed a motion to join as parties to the proceeding Nelson, as a noncomplying employer, and SAIF as processing agent for Nelson. Claimant opposed the motion. The motion was denied by the assistant presiding referee by order dated October 12, 1988. SAIF again presented its motion at hearing on October 13, 1988. The hearings Referee also denied the motion.

CONCLUSIONS OF LAW AND OPINION

Remand

We may remand to the Referee if we find that the case has been "improperly, incompletely or otherwise insufficiently developed." ORS 656.295(5). Claimant requests that we remand in order to have Nelson joined as a party at the hearing. We conclude, however, that claimant's request for joinder is inappropriate on both procedural and substantive grounds.

Procedurally, we find that claimant cannot, on review, raise the issue of joinder. Prior to hearing, SAIF moved to have Nelson joined as a party. Claimant opposed joinder. Relying in part upon claimant's objection to joinder, the assistant presiding referee denied the motion. SAIF does not now contest the denial of its joinder motion. Instead, claimant attempts to obtain remand for purposes of joinder. We conclude that, due to his objection to joinder at hearing, claimant is estopped from asserting entitlement to joinder on review. Beck v. Southern Oregon Health Services, Inc., 255 Or 590, 593 (1970); Burgess v. Charles A. Wing Agency, 139 Or 614, 624 (1932).

Moreover, substantively the record is insufficient to support claimant's request for joinder. In this regard, the applicable administrative rule provides as follows:

> "Other insurers or employers shall be joined as parties in the pending case if the referee finds on motion of an insurer

> or self-insured employer that joinder is necessary to determine an issue of responsibility, and if the insurer or self-insured employer requesting joinder has acted, immediately after it first knew or should have known there was a question of responsibility, to involve the other insurer(s) or employer(s) in accordance with OAR Chapter 436, Division 60." Former OAR 438-06-065(2).

As early as July 20, 1988, SAIF had a report from its investigator which provided notice that Nelson was potentially responsible for the claim. And yet, there is nothing in the record to indicate that SAIF shared records with Nelson as required by OAR 436-60-180(5). Thus, Nelson presumably had no opportunity to promptly accept or deny the claim. Moreover, we are unable to find that SAIF acted to involve Nelson "immediately after it first knew or should have known there was a question of responsibility ***." Consequently, even if we were to permit claimant to, in effect, step into the shoes of SAIF on review and reassert SAIF's prior request to join Nelson, we would nevertheless conclude that the record did not substantively support joinder.

Our decision on this issue should not be interpreted as disapproval of joinder or consolidation where there is a dispute about who is an injured worker's employer. To the contrary, joinder is the preferable approach to this type of case. Rather, our decision to deny remand for purposes of joinder is a reflection of the peculiar posture of this matter as it appears before us on review.

Jurisdiction

Nelson was not a party at hearing. In addition, although SAIF as insurer for Fuller's was a party at hearing, SAIF as processing agent for a noncomplying employer under ORS 656.054 was not a party at hearing. Accordingly, we conclude that the Referee lacked personal jurisdiction over either Nelson or SAIF as purported processing agent for Nelson.

Even had the Referee jurisdiction of the parties, the sole statutory authority for referring a claim against a noncomplying employer is ORS 656.054. That statute requires the Director of the Department of Insurance and Finance to refer such a claim to SAIF. There is no statutory authority for a referee to refer such a claim to SAIF for processing. For that reason also, the Referee's order is erroneous.

Consequently, that portion of the Referee's order that directed SAIF to accept and process the claim on behalf of Nelson shall be vacated.

Compensability

It remains for us to determine whether the Referee correctly concluded that claimant was an employee of Nelson, rather than an employee of Fuller's. This issue depends, in turn, upon whether Nelson was himself an employee of Fuller's and was, therefore, claimant's supervisor; or whether, instead, Nelson was

an independent contractor. The Referee concluded that Nelson was an independent contractor and that claimant was his employee. We agree.

As recently stated by the Court of Appeals:

> "The test for determining who is a subject worker within the meaning of the Workers' Compensation Act is the employer's right to control the performance of the services. ORS 656.050(14) and (27). The test requires an application of the traditional 'right to control' analysis and a consideration of the 'nature of the work.' Woody v. Waibel, 276 Or 189, 196, 554 P2d 492 (1976)." Castle Homes, Inc. v. Whaite, 95 Or App 269, 271 (1989).

The factors to be considered under the traditional test of the right to control include: (1) direct evidence of the right to, or the exercise of, control; (2) the method of payment; (3) the furnishing of equipment; and (4) the right to fire at will without liability. Id. at 272.

We first note that any evidence of actual control supports an employer-employee relationship. However, absence of any evidence of the actual exercise of control does not require an independent contractor finding. This results from the fact that it is the right to control services that is determinative, not actual exercise of control. Bowser v. State Ind. Acc. Comm., 182 Or 42, 49-56 (1947). As applied to this case, Fuller might not exercise any actual control over Nelson and his crew, but he may, nevertheless, retain the right to control their services.

Turning to the record, we do not find any direct evidence of either the right to, or the actual exercise of, control. Although Fuller told Nelson which parts of the building to work on and what needed to be done, thereafter Nelson and his crew were left to perform the work as they saw fit. The only evidence that Fuller retained any right to control the performance of the work was the fact that he occasionally checked on the progress of the work. However, the evidence otherwise establishes that Nelson was left to his independent judgment on how best to perform the work. Therefore, we find no direct evidence that Fuller retained the right to control the services of Nelson and his crew. Nor is there evidence that Fuller actually exercised any control over their services.

We turn next to an examination of the parties' rights to terminate the relationship. If Fuller could fire Nelson without liability should Nelson not perform any part of the job to Fuller's satisfaction, then Nelson's supposed independence would be illusory. This would be true regardless of the fact that Fuller did not exercise any actual control over Nelson and his crew. Bowser, supra, 182 Or at 56. In this regard, the parties did not have a written contract. Consequently, it is difficult to determine whether Fuller had the right to fire Nelson and his crew at will without incurring liability. However, the fact that Fuller had contracted with Nelson to perform a single, specific task, i.e., demolition work on Fuller's new building, and that Nelson and his crew had commenced such work, suggests that Fuller

was not free to terminate the agreement at any time without liability.

The evidence regarding the method of payment is somewhat conflicting. The agreement between Fuller and Nelson provided that Fuller would pay an amount based upon an hourly wage for each individual multiplied by the number of hours worked. In general, payment of an hourly wage suggests an employer-employee relationship. Bowser v. State Ind. Acc. Comm., 182 Or 42, 60 (1947). However, the evidence establishes that the hourly wage figures were used by Fuller and Nelson to simply arrive at an approximate contract price. In this regard, claimant was not hired at a particular hourly wage. Instead, Nelson was free to pay to claimant whatever amount he wanted to pay. And, in fact, claimant did not know what he would be paid by Nelson until actually receiving payment. (Tr. 17). We conclude that, under these facts, the method of payment supports an independent contractor relationship.

With regard to the furnishing of equipment, Nelson was to provide all of his own equipment. This is also evidence of an independent contractor relationship.

In sum, the relevant factors regarding the traditional right-to-control test support an independent contractor relationship.

We turn next to an examination of the nature-of-the-work test. See Woody v. Waibel, supra, 276 Or at 196-98. In this regard, demolition of the proposed restaurant building was clearly not a continuing, integral part of Fuller's business. Instead, the demolition work was an isolated event not to be anticipated in Fuller's ordinary business operation. Moreover, Fuller and Nelson had no ongoing business relationship. Fuller is a restraunteur; Nelson deals in scrap metal. On these facts, we conclude that the relative nature of the work was such as to reinforce a finding that Nelson was an independent contractor.

Despite this conclusion, Fuller might still be responsible for providing workers' compensation coverage for Nelson and his crew pursuant to ORS 656.029(1). That statute provides:

> "If a person awards a contract involving the performance of labor where such labor is a normal and customary part or process of the person's trade or business, the person awarding the contract is responsible for providing workers' compensation insurance coverage for all individuals, other than those exempt under ORS 656.027, who perform labor under the contract ***."

ORS 656.029 applies only to persons awarding contracts for performance of labor where such labor is a "normal and customary part or process of the person's trade or business." Fuller's trade or business is that of running a restaurant, not that of demolishing or renovating buildings. Fuller's immediate plan was to lease the building and to hold it as an investment. Although he contemplated moving his restaurant into the building some years hence, that incidental relationship is not sufficient to qualify it as part and parcel of the "normal and customary"

business of running a restaurant. Therefore, we conclude that Fuller was not responsible pursuant to ORS 656.029 for providing workers' compensation coverage for claimant.

Attorney Fees

Claimant alleges entitlement to a carrier-paid attorney fee pursuant to ORS 656.386(1) for his counsel's services at hearing. That provision entitles a claimant to a carrier-paid fee where the claimant finally prevails on a rejected claim. Claimant argues that the Referee's order "in essence" set aside a "de facto" denial on Nelson's part. However, pursuant to our decision, that portion of the order upon which claimant relies has been vacated. Consequently, even if we were to accept claimant's characterization of the Referee's order, claimant has not finally prevailed on a rejected claim. The request for attorney fees is denied.

ORDER

The Referee's order, dated November 22, 1988, is vacated in part and affirmed in part. That portion of the order that found Nelson to be a noncomplying employer and that remanded the claim to the SAIF Corporation for processing on behalf of Nelson is vacated. The remainder of the order is affirmed.

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

WCB 87-04327
July 27, 1989
Order on Review

Reviewed by Board Members Johnson and Crider.

Claimant requests review of those portions of Referee Wasley's order that: (1) approved the SAIF Corporation's offset of overpaid permanent partial disability against her award of permanent total disability; and (2) refused to assess a penalty and associated attorney fee for the offset. In its respondent's brief, SAIF argues that the Referee erred in: (1) failing expressly to approve its offset of overpaid temporary total disability against claimant's award of permanent total disability; and (2) assessing a penalty and associated attorney fee for the offset. We reverse in part and affirm in part.

ISSUES

1. Whether SAIF's offset of overpaid permanent partial disability against claimant's award of permanent total disability was procedurally and substantively proper.

2. Whether SAIF had a reasonable basis for concluding that its offset of overpaid permanent partial disability was proper.

3. Whether SAIF's offset of overpaid temporary total disability against claimant's award of permanent total disability was procedurally and substantively proper.

4. Whether SAIF had a reasonable basis for concluding that its offset of overpaid temporary total disability was proper.

FINDINGS OF FACT

Claimant compensably injured her left leg and hip in 1978. The claim was closed by Determination Order in January 1980 with a 25 percent scheduled award. The claim was subsequently reopened and claimant underwent surgery on her left hip. The claim was closed again by Determination Order dated September 18, 1985. The Determination Order granted claimant temporary total disability compensation through August 26, 1985 and an award of 60 percent unscheduled permanent partial disability. The monetary value of the permanent disability award was $16,320. The Determination Order also granted SAIF authorization for "[d]eduction of overpaid temporary disability, if any, from unpaid permanent disability." Under the medically stationary date set by the Determination Order, SAIF had an overpayment of temporary disability compensation in the amount of $345.87. SAIF began paying permanent partial disability installments pursuant to ORS 656.216(1).

Claimant requested a hearing on the Determination Order which came before Referee Neal. In an Opinion and Order dated January 23, 1987, Referee Neal concluded that claimant had become medically stationary on November 12, 1984 and terminated claimant's entitlement to temporary total disability compensation as of that date. Referee Neal also awarded claimant permanent total disability effective November 13, 1985. In an order dated January 27, 1987, Referee Neal amended the effective date of claimant's permanent total disability award to November 12, 1984 to coincide with her conclusion regarding claimant's medically stationary date.

Referee Neal's adjustment of claimant's medically stationary date increased SAIF's temporary disability overpayment from $345.87 to $4,954.47. The Referee's award of permanent total disability resulted in a permanent partial disability overpayment of $8,160.88. The total overpayment, therefore, was $13,115.35. SAIF did not request authorization from Referee Neal to offset this overpayment against claimant's permanent total disability award and neither of Referee Neal's orders addressed the issue.

SAIF requested Board review of Referee Neal's amended order, raising extent of disability and offset as issues. Pending Board review, SAIF offset $11,000 of its total overpayment against claimant's retroactive award of permanent total disability and began deducting the balance of the overpayment from claimant's monthly permanent total disability payments at the rate of 25 percent of each payment. Claimant requested a hearing and sought penalties and attorney fees in connection with SAIF's offsets. In an order dated October 21, 1987, Referee Wasley concluded that SAIF's offsets were improper and ordered SAIF to pay a 25 percent penalty on the compensation withheld and an attorney fee of $750.

On November 10, 1987, the Board issued its original Order on Review of Referee Neal's order. Elsie L. Hobkirk, 39 Van Natta 1131 (1987). The Board affirmed the Referee's award of permanent total disability, but held that SAIF was entitled to offset its permanent partial disability overpayment against the permanent total disability award. After receiving the Board's order, SAIF requested that Referee Wasley reconsider his order in the enforcement action. Referee Wasley abated his order on November 19, 1987. On February 22, 1988, Referee Wasley issued an

amended order which recognized the offset authorized by the Board but otherwise ordered SAIF to "comply in all respects" with Referee Neal's amended order. Referee Wasley then assessed a 25 percent penalty on "the sums presently due" under Referee Neal's order and an attorney fee of $750. Claimant requested Board review. SAIF did not formally cross-request review, but raised the issue of the propriety of its offset of overpaid temporary disability in its respondent's brief.

In the meantime, the Board abated its original Order on Review of Referee Neal's order. In an Order on Reconsideration dated July 5, 1988, the Board determined that it had erred in authorizing the offset requested by SAIF. Elsie L. Hobkirk, 40 Van Natta 778 (1988), modified on other grounds, 40 Van Natta 1947 (1988). The Board concluded that SAIF had waived its right to request authorization for an offset from the Hearings Division or the Board because it had failed to raise the issue at the hearing level. The Board commented, however, that it was not deciding the issues of the propriety or reasonableness of SAIF's unilateral actions as those issues were before the Hearings Division in another case (i.e. the present case).

FINDINGS OF ULTIMATE FACT

1. SAIF had no authorization to offset its permanent partial disability overpayment against claimant's award of permanent total disability.

2. SAIF had no reasonable basis for concluding that its offset of overpaid permanent partial disability was proper.

3. SAIF did not have authorization to offset its temporary total disability overpayment against claimant's award of permanent total disability.

4. SAIF did not have a reasonable basis for concluding that its offset of overpaid temporary total disability was proper.

CONCLUSIONS OF LAW

The Propriety of SAIF's Offset of Overpaid Permanent Partial Disability

Referee Wasley concluded that SAIF had properly offset its permanent partial disability overpayment against claimant's award of permanent total disability based upon the Board's retroactive authorization of the offset in its original order on review of Referee Neal's order. As noted above, however, the Board subsequently reconsidered its order and concluded that SAIF had waived its right to request authorization for its offset. That basis for the Referee's order, therefore, is no longer viable.

As an alternative to the Referee's reasoning, SAIF contends that its offset was authorized "as a matter of law" under the rule of Pacific Motor Trucking Co. v. Yeager, 64 Or App 28 (1983). In that case, the court ruled that a claimant who is receiving payments for permanent total disability is not entitled to separate additional payments for permanent partial disability. Claimant contends that Yeager relates only to SAIF's substantive entitlement to an offset and that regardless of such entitlement, SAIF's failure to obtain express authorization for its offset renders the offset invalid.

We agree with claimant. Referee Neal's amended order awarded claimant permanent total disability effective November 12, 1984. The order did not authorize an offset of overpaid permanent partial disability. SAIF had no right to take such an offset without authorization. Forney v. Western States Plywood, 66 Or App 155 (1983), aff'd, 297 Or 628 (1984). Despite its request for Board review, SAIF had a duty to pay the compensation awarded by Referee Neal within 30 days of her order. ORS 656.313(1); OAR 436-60-150(5)(b). Under these circumstances, SAIF's unilateral offset was improper and the compensation which SAIF should have paid pursuant to Referee Neal's order, but did not, must now be paid regardless of whether SAIF is substantively entitled to an offset. See ORS 656.313(2); Spivey v. SAIF, 79 Or App 568, 571-72 (1986); Hutchinson v. Louisiana-Pacific Corp., 67 Or App 577, 580-81, rev den 297 Or 339 (1984).

Penalty and Attorney Fee for SAIF's Offset of Overpaid Permanent Partial Disability

A penalty of up to 25 percent and an associated attorney fee may be assessed against a carrier which unreasonably delays or refuses to pay compensation due. ORS 656.262(10); 656.382(1). SAIF's only argument for the reasonableness of its unilateral offset was that it needed no authorization for the offset by virtue of the rule of Pacific Motor Trucking Co. v. Yeager, supra. SAIF's reading of Yeager was not reasonable in light of Forney v. Western States Plywood, supra, and other cases which clearly state that a carrier must seek authorization from the Evaluation Section, a Referee, the Board or a court before taking an offset, even if all concede that the carrier is substantively entitled to it. Under these circumstances, we conclude that a full 25 percent penalty and an attorney fee of $750 is warranted in connection with the compensation improperly withheld by SAIF.

The Propriety of SAIF's Offset of Overpaid Temporary Total Disability

Neither Referee Neal nor the Board authorized an offset of overpaid temporary disability compensation. The reasoning we applied to SAIF's offset of overpaid permanent partial disability, therefore, would appear to mandate the same result on this issue. SAIF contends, however, that authorization for its offset of overpaid temporary total disability was provided by the September 1985 Determination Order. That order authorized "[d]eduction of overpaid temporary disability, if any, from unpaid permanent disability." Although the medically stationary date set by the Determination Order resulted in a temporary disability overpayment of only $345.87, Referee Neal's adjustment of the medically stationary date increased the amount of the overpayment to $4,954.47.

SAIF contends that the offset authorization granted by the Determination Order applied to the temporary disability overpayment created by Referee Neal's order. We disagree.

An insurer may not reduce a claimant's benefits without "prior authorization" from the Evaluation Section, Referee, Board, or court. Forney v. Western States Plywood, supra. Here, the temporary disability "overpayment" created by Referee Neal's order occurred subsequent to the September 1985 Determination Order. Consequently, the Evaluation Division could not have granted prior

authorization as required by Forney. See Wayne W. Wittrock, 39 Van Natta 825 (1987). Instead, the prior authorization to offset granted by the September 1985 Determination Order applies solely to the $345.87 temporary disability overpayment existing at the time of the Evaluation Division's determination. Moreover, because Referee Neal did not address the "overpayment" issue, SAIF did not have authorization to offset any additional alleged overpayment. Accordingly, we agree with the Referee's assessment of a penalty and attorney fee for SAIF's unauthorized offset of these temporary disability benefits. ORS 656.262(10); 656.382(1).

ORDER

The Referee's order dated October 21, 1987, as amended February 22, 1988, is reversed in part and affirmed in part. The SAIF Corporation's offset of overpaid permanent partial disability was unauthorized and unreasonable. SAIF shall repay claimant the amount withheld by reason of this offset. A penalty equal to 25 percent of this withheld amount and an associated attorney fee of $750 is assessed against SAIF in connection with the offset. The Referee's assessment of a 25 percent penalty based on SAIF's unauthorized offset of temporary disability benefits and an associated attorney fee of $750 is affirmed. For services on Board review concerning the temporary disability issue, claimant's attorney is awarded a reasonable fee of $750, to be paid by the SAIF Corporation.

SEDAYAN ISHAQUE, Claimant
David Hollander & Associates, Claimant's Attorneys
Beers, et al., Defense Attorneys
Schwabe, et al., Defense Attorneys

WCB 84-07031
July 27, 1989
Order of Dismissal

EBI Companies moves for dismissal of claimant's request for review of Referee Thye's order on the ground that it did not receive timely notice of the request. The motion is granted.

FINDINGS

Referee Thye's Opinion and Order in WCB Case No 84-07031 issued August 26, 1987, naming claimant, EBI, and Fremont Indemnity as parties. The Referee upheld both carrier's denials of claimant's current cervical condition. On September 12, 1987, claimant wrote a letter to the Board requesting a "new hearing date," because the first hearing had been "unfair." There is no indication either insurer was served with this letter.

Claimant's letter was received by the Board on September 16, 1987 and was treated as a hearing request. Thereafter, a hearing was scheduled under WCB Case No. 87-14238, with claimant and Fremont Indemnity (United Employers Insurance) as parties. Fremont's counsel received a copy of claimant's letter on or about September 28, 1987. The copy of the letter was provided by Fremont's claims examiner. Neither EBI nor its counsel received a copy of claimant's letter.

On October 1, 1987, Fremont moved for dismissal of the hearing request. On October 8, 1987, claimant's former counsel indicated that the request for hearing should have been construed as a request for Board review. On November 10, 1987, Referee Foster dismissed the hearing request in WCB Case No. 87-14238 on

the basis that it had been misconstrued as a request for hearing and therefore there were no viable issues to be resolved.

On November 23, 1987, claimant "requested a review." The Board acknowledged this request on November 30, 1987, directing the acknowledgment to both Fremont and EBI. Receipt of this acknowledgment constitutes EBI's first notice of claimant's request for review.

CONCLUSIONS

A Referee's order is final unless, within 30 days after the date on which a copy of the order is mailed to the parties, one of the parties requests Board review under ORS 656.295. ORS 656.289(3). Requests for Board review shall be mailed to the Board and copies of the request shall be mailed to all parties to the proceeding before the Referee. ORS 656.295(2). Compliance with ORS 656.295 requires that statutory notice of the request for review be mailed or actual notice be received within the statutory period. Argonaut Insurance Co. v. King, 63 Or App 847, 852 (1983). "Party" means a claimant for compensation, the employer of the injured worker at the time of injury and the insurer, if any, of such employer. ORS 656.005(19).

Here, claimant's September 12, 1987 letter was received by the Board within 30 days of Referee Thye's August 26, 1987 order. Therefore, assuming that the letter constitutes a request for review, it was filed timely. See ORS 656.289(3).

However, the record fails to establish that all parties to the proceeding have received timely notice. Pursuant to EBI's counsel's affidavit, the claim file for EBI does not contain a copy of claimant's letter. Moreover, since EBI was not included as a party to the scheduled hearing in WCB Case No. 87-14238, it did not receive notice of claimant's letter through receipt of a copy of the Hearing Division's acknowledgment of that hearing request. Consequently, EBI's first notice of a request for Board review of Referee Thye's order was its receipt of the Board's November 30, 1987 acknowledgment letter. Such notice is well in excess of 30 days from the date of issuance of the August 26, 1987 order.

Inasmuch as EBI did not receive notice of the request for Board review within 30 days of Referee Thye's August 26, 1987 order, we lack jurisdiction to review the 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.

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).

IT IS SO ORDERED.

MONTY R. JONES, Claimant
Sellers & Jacobs, Claimant's Attorneys
Steven Hallock, Defense Attorney

WCB 87-15511
July 27, 1989
Order on Review

Reviewed by Board Members Johnson and Crider.

The insurer requests review of Referee Thye's order that set aside its objection to claimant's choice of an out-of-state attending physician. We affirm.

ISSUE

Medical Services. Whether the insurer's veto of claimant's choice of an out-of-state attending physician was proper?

FINDINGS OF FACT

Claimant suffered a compensable back injury on March 20, 1987. Claimant was employed in Oregon and resided in Vancouver, Washington. Claimant first sought medical treatment from Dr. Wagner, M.D., on referral from his employer. Dr. Wagner's office was located in the Portland area. Dr. Wagner subequently referred claimant to Dr. Kim for a neurological examination. Dr. Kim's office was located in Vancouver, Washington.

Claimant was dissatisfied with the treatment he was receiving from Drs. Wagner and Kim. On May 13, 1987, he transferred his care to Dr. Bain, chiropractor. Dr. Bain's office was located in Vancouver, Washington.

On May 20, 1987, Dr. Bain completed a First Medical Report form. He sent this form, along with a narrative report, to the insurer. On May 24, 1987, Dr. Bain responded by letter to an inquiry from claimant's vocational counselor. At the insurer's request, Dr. Bain completed supplemental medical report forms in mid and late June, 1987. On August 31, 1987, Dr. Bain responded to an inquiry from the insurer indicating that he disagreed with the report of an independent medical examination. He gave no reasons for his disagreement.

On September 16, 1987, the insurer notified claimant that, pursuant to OAR 436-60-050(5), no further treatment by Dr. Bain would be authorized. Instead, the insurer indicated that treatment by Dr. Wagner would be authorized and instructed claimant to schedule an appointment with Dr. Wagner for his continued medical care.

On referral from Dr. Bain, claimant subsequently transferred his care to Dr. Milam, chiropractor. Dr. Milam's office was located in Oregon. Up to the date of hearing, the insurer had continued to pay for Dr. Milam's treatments.

The insurer objected to Dr. Bain because he continued treatment and time loss and would not release claimant to return to work whereas Dr. Wagner, Dr. Kim, and a panel of the Orthopaedic Consultants had all opined that claimant could return to work.

CONCLUSIONS OF LAW AND OPINION

We note preliminarily that the Referee's written order

incorporates his findings and conclusions orally entered on the record at hearing. However, those findings and conclusions are not a transcribed portion of the record on review. Consequently, we do not have the advantage of the Referee's reasoning in reaching his decision. Nevertheless, in light of our de novo review authority, we proceed to a discussion of the merits of the claim. See ORS 656.295(5).

The insurer contends that its authority to veto claimant's choice of an out-of-state physician is subject to only two limited exceptions. First, the insurer concedes that it may not deny an entire category of health care providers. See Reynaga v. Northwest Farm Bureau, 300 Or 255 (1985). Second, the insurer concedes that it may not deny an individual health care provider where the denial would effectively preclude access to an entire category of otherwise reasonable and necessary treatment. See Day v. S & S Pizza Co., 77 Or App 711 (1986).

In Reynaga, supra, claimant was receiving treatment by out-of-state chiropractors. The insurer wrote claimant stating that payments for further out-of-state medical care would be made only if the care were provided by an orthopedist. When claimant nevertheless obtained treatment by an out-of-state chiropractor, the insurer refused to pay the bill. A Referee, the Board and the Court of Appeals all upheld the denial of payment. On review, the Supreme Court reversed and remanded.

The Court held that an insurer may not preclude claimant from seeking treatment by an entire category of health service providers. In reaching this conclusion, the Court discussed the applicability of ORS 656.245 which provides, in relevant part:

> "(1) For every compensable injury, the insurer or the self-insured employer shall cause to be provided medical services for conditions resulting from the injury for such period as the nature of the injury or the process of the recovery requires,....
>
> ".....
>
> "(3) The worker may choose an attending doctor or physician within the State of Oregon. The worker may choose the initial attending physician and may subsequently change attending physicians four times without approval from the director...." (emphasis added).

The Court noted that the statute was silent as to whether a worker may also choose a physician outside the state. The Court further noted that neither legislative history nor prior caselaw provided useful guidance on this issue. The Court went on to find that ORS 656.245(1) requires insurers to provide reasonable medical services without regard to the injured worker's geographic location. The Court then concluded that an insurer may not deny an entire category of otherwise reasonable out-of-state medical services. Id. at 262.

Subsequent to the Supreme Court's decision in Reynaga, the Court of Appeals issued its decision in Day v. S & S Pizza Co., 77 Or App 711 (1986). The issue before the court in Day involved

an insurer's denial of surgery by an out-of-state physician. The physician was one of only two physicians in the country who performed the desired surgical procedure. The court concluded that the insurer could not exercise its limited authority to veto claimant's choice of an out-of-state physician where to do so effectively precluded claimant from a particular type of surgery.

We draw the following conclusions based upon our reading of Reynaga and Day. First, an injured worker has the initial right to select an out-of-state attending physician. Second, that choice of attending physician is subject to an insurer's right of veto. Third, the insurer's right of veto cannot operate in a given case to deprive a worker of reasonable and necessary medical treatment. In the words utilized by the court in Day:

> "[T]he insurer's power to veto claimant's choice of an out-of-state physician under ORS 656.245(3) is not unlimited. That power does not limit claimant's right to receive medical services under ORS 656.245(1), wherever she is." Day, supra, at 716.

The insurer relies upon OAR 436-60-050(5) in support of its objection to Dr. Bain's status as claimant's attending physician. The insurer argues that OAR 436-60-050(5) does not limit the grounds on which the insurer may object to claimant's choice of an out-of-state attending physician. That rule provides:

> "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."

On its face, the rule imposes no restrictions on the insurer's right to object to a worker's choice of an out-of-state attending physician. And yet, the courts have unequivocally imposed limitations on that veto power.

The insurer concedes that the limitations of Reynaga and Day can be "read into" the rule. We agree. To interpret the rule otherwise would result in a conclusion that the rule violates the statute. We disagree, however, with the insurer's contention that the only limitations on its right to object pursuant to OAR 436-60-050(5) are those resulting from the holdings in Reynaga and Day. We think that the insurer's reading of those decisions is too restrictive. Rather, as stated above, we conclude that those decisions stand for the proposition that an injured worker is entitled to reasonable medical services without regard to geographical location, and that an insurer is authorized to object to the worker's choice of out-of-state attending physician only where its exercise of that veto power does not operate to deny claimant reasonable medical services. We interpret the rule accordingly.

Here, the insurer objected to Dr. Bain as claimant's

attending physician. The insurer's representative testified that its objection was based upon Dr. Bain's insistence on continued treatment of claimant, and the fact that Dr. Bain would not release claimant to return to work whereas Drs. Wagner and Kim and the Orthopaedic Consultants had all opined that claimant was able to return to work. In addition, the insurer instructed claimant to obtain further medical care from Dr. Wagner.

The insurer's motive for rejecting Dr. Bain as claimant's treating physician is improper. The insurer's veto was not prompted out of concern that Dr. Bain would not comply with Oregon workers' compensation reporting requirements. See Day, supra at 716. Instead, the insurer's veto was an attempt to interfere with the physician's exercise of his responsibilities as attending physician. It circumvented appropriate claims processing avenues. In this regard, if the insurer believed that Dr. Bain's treatments were not reasonable and necessary, then the appropriate method to challenge those treatments was to issue a denial pursuant to ORS 656.262. Similarly, if the insurer believed that claimant was medically stationary and capable of returning to his regular work, then the insurer should have sought claim closure. See ORS 656.268.

The effect of the insurer's veto, coupled with its directive to claimant that he treat with Dr. Wagner, is to deny out-of-state access to claimant's choice of treatment modality -- chiropractic -- in violation of the spirit of Reynaga, supra.

ORDER

The Referee's order dated February 5, 1988 is affirmed. Claimant's attorney is awarded an assessed fee of $855, to be paid by the insurer.

FRANKLIN H. KING, Claimant
WHITSELL MANUFACTURING Company, Inc, Employer
WALTER F. WHITSELL & BONNIE M. RENFRO, Employers
Malagon, Moore & Johnson, Claimant's Attorneys
Donald Dickerson, Attorney
SAIF Corp Legal, Defense Attorney
Mark Braverman, Assistant Attorney General

WCB 88-11015
July 27, 1989
Order of Dismissal

Reviewed by Board Members Crider and Ferris

Whitsell Manufacturing, Inc., (Whitsell) an alleged noncomplying employer, requested review of Referee Higashi's order that affirmed a Director's Proposed and Final Order finding Whitsell to be a noncomplying employer. The Department of Insurance and Finance has requested "reconsideration" of the Referee's order, contending that the order lacks an accurate statement concerning the parties rights of appeal. We dismiss the request for review for lack of jurisdiction.

FINDINGS OF FACT

On May 25, 1988, a Proposed and Final Order from the Department of Insurance and Finance issued. Pursuant to the order, Whitsell was declared a noncomplying employer. Whitsell requested a hearing.

At the hearing, evidence was taken regarding the noncompliance order, as well as matters concerning the claim.

However, those issues pertaining to the claim were continued for a further hearing and the Referee proceeded to address only the noncompliance issue. On March 31, 1989, the Referee issued his order. Finding Whitsell to be a noncomplying employer, the Referee affirmed the Department's proposed and final order. On April 24, 1989, the Referee issued an Amended Order. In addition to adhering to his prior conclusions, the Referee awarded an assessed fee.

The Referee's orders advised the parties that, should they object to the orders, they could request Board review within 30 days. Within 30 days of the Referee's orders, the alleged noncomplying employer requested Board review.

CONCLUSIONS OF LAW

When a Referee issues an order concerning a Director's order of noncompliance or any other matters unrelated to a claim, the Referee's order becomes a final order of the Director and must be appealed directly to the Court of Appeals. ORS 183.480(1), (2); Denise K. Rodriquez, 40 Van Natta 1788 (1988). When an order declaring a person to be a noncomplying employer is contested at the same hearing as a matter concerning a claim pursuant to ORS 656.283 and 656.704, the review thereof shall be as provided for a matter concerning a claim. ORS 656.740(4)(c). Matters concerning a claim are those matters in which a worker's right to receive compensation, or the amount thereof, are directly in issue. ORS 656.704(3).

Here, the hearing involved issues which included the Director's noncompliance order, as well as matters pertaining to the claim. Yet, the matters concerning the claim were continued for further hearing, while the Referee proceeded to issue an order that solely pertained to the Director's order of noncompliance. Since the Referee's order was expressly limited to the Director's order and not to any matters concerning a claim, we conclude that appeal from that order must be directed to the Court of Appeals. See ORS 183.410(1), (2); 656.740(4).

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

IT IS SO ORDERED.

ALLAN KYTOLA, Claimant
Allan Coons, Claimant's Attorney
Karen M. Werner, Attorney
Brian L. Pocock, Defense Attorney

WCB 86-06379 & 87-07526
July 27, 1989
Order on Review

Reviewed by Board Members Crider and Johnson.

The self-insured employer requests review of those portions of Referee Mongrain's order that: (1) set aside its denial of claimant's current neck condition and associated need for medical services; and (2) declined to authorize an offset of allegedly overpaid permanent total disability benefits.

The Board affirms the order of the Referee.

ISSUES

1. Whether claimant's compensable injuries are a material contributing cause of his current neck condition and associated need for medical services.

2. Whether the self-insured employer should be allowed to offset allegedly overpaid permanent total disability benefits.

FINDINGS OF FACT

The Board adopts the Referee's findings of fact and makes the following additional findings.

Claimant's compensable injuries of December, 1972 and May, 1974 are a material contributing cause of his current neck condition and associated need for medical services.

CONCLUSIONS OF LAW

Medical Services

A worker is entitled to reasonable and necessary medical services for the disabling results of a compensable injury, even if preexisting problems contribute to his disability. Van Blokland v. Oregon Health Sciences University, 87 Or App 694 (1987). The compensable injury need not be the sole or principal cause of a worker's need for medical services, but only a material contributing cause. Van Blokland, 87 Or App at 698.

Here, the Referee apparently decided this case on the procedural basis that claimant had received a prior award of unscheduled permanent disability to his neck. Although we agree with the Referee's conclusion that claimant's current neck condition is compensable, we do so on the merits of the evidence.

In our view, the etiology of claimant's current neck condition presents a complex medical question. Although claimant's testimony is probative, resolution of this case largely turns on the medical evidence. See Kassahn v. Publishers Paper Co., 76 Or App 105 (1985); Uris v. Compensation Department, 247 Or 420 (1967). Drs. Corrigan, Gilsdorf, and Dunn opine that claimant's compensable injuries materially contributed to his current cervical condition. Drs. Howell and Fechtel believe that claimant's current condition is solely due to preexisting degenerative changes. Dr. Campagna's opinion is equivocal.

Given that Drs. Corrigan, Gilsdorf, and Dunn have each periodically treated claimant over the last 10 years, we are persuaded by their collective opinions. Unlike Drs. Howell and Fechtel, Corrigan, Gilsdorf, and Dunn have personally observed the progression of claimant's preexisting degenerative condition since before or shortly after his compensable injuries of 1972 and 1974. See Weiland v. SAIF, 64 Or App 810 (1983). Even so, they each opine that claimant's compensable injuries materially contributed to the causation of his current neck condition and resulting need for surgery in February, 1986.

Accordingly, we agree with the Referee's conclusion that claimant has proven the compensability of his current neck condition and associated need for medical services.

Offset

The Board affirms and adopts that portion of the Referee's opinion and conclusions of law, which found that the employer was not entitled to offset permanent total disability benefits paid pursuant to a prior Referee's Order pending reversal of the award by the Board. Sullivan v. Banister Pipeline American, 91 Or App 493 (1988); United Medical Laboratories v. Bohnke, 81 Or App 144 (1986).

ORDER

The Referee's order, dated February 2, 1988, is affirmed. Claimant's attorney is awarded an assessed fee of $750 for services on review, to be paid by the self-insured employer.

ANNA M. MOEN, Claimant
Richard D. Adams, Claimant's Attorney
Jenny A. Ogawa, Defense Attorney

WCB 87-11093
July 27, 1989
Order on Review

Reviewed by Board Members Crider and Johnson.

The self-insured employer requests review of Referee Melum's order that set aside its denial of claimant's mental stress condition. In addition, the employer requests that the Board remand this matter to the Referee for further evidence taking.

The Board affirms the order of the Referee.

ISSUES

1. Whether this case should be remanded to the Referee for further evidence taking.

2. Whether claimant sustained a compensable mental stress condition.

FINDINGS OF FACT

Remand

At the beginning of the hearing, the Referee stated that he had previously declined to grant a motion from the employer to postpone the hearing. The Referee went on to state that the record would be held open until November 15, 1987, in order to allow the deposition of Dr. Klein and any additional medical reports submitted prior to that date.

At the close of the hearing, the Referee expressed a desire for legal citations from the parties in their closing arguments. The Referee seemed to indicate a preference for written, rather than verbal, closing arguments, but, ultimately left it up to the parties, stating, inter alia: "But I'm -- I will entertain closing arguments at this time and from my standpoint, I'm particularly interested in your citation of legal authorities." The parties then proceeded to make their respective closing statements before the Referee.

There was no agreement between the Referee and the parties that the record would be left open for the submission of written closing arguments.

Klein was deposed on November 10, 1987. The employer's

attorney submitted the transcript of Klein's deposition on November 25, 1987, and the Referee admitted it into evidence. On December 9, 1987, claimant's attorney submitted a rebuttal report from Dr. Gardner, dated December 3, 1987. The Referee admitted the Gardner report into evidence, closed the record, and issued his Opinion and Order on December 17, 1987.

Thereafter the employer requested the Referee to abate his order, recuse himself from deciding the matter, and then have the case reconsidered by another Referee. On January 11, 1988, the Referee denied the employer's motion.

Compensability

Claimant, 54 at hearing, was involved in a non-work related motor vehicle accident in May, 1985. She suffered injuries to her head, face, and ribs. In addition, she developed psychological problems consisting of post-traumatic depression, memory loss, low functional level, and uncontrollable rages. Her memory loss interfered with her ability to perform her job as a Quality Control Supervisor. She also began to miss some work.

Claimant began working for the employer, an electronic products manufacturer, in 1977. Since 1981, she has been a supervisor of Quality Control Inspectors.

In 1986, claimant experienced marital problems, which have now largely resolved. She also experienced problems due to her adopted son's substance abuse and driving offenses.

A neuropsychological evaluation performed by Dr. Pearson, a psychologist, in July, 1986, revealed, inter alia, a post concussion syndrome perhaps exacerbated by her marital difficulties.

In February, 1986, claimant began to treat with Dr. Gardner, a psychiatrist. Gardner diagnosed, inter alia, symptoms of a typical closed head injury including, emotional disequalibrium, depression, attention deficit, unpredictability, and inappropriate emotional responses.

Claimant received her first and only written warning in December, 1986, for inappropriately berating an employee in front of other workers. At that time, the employer was pushing for higher productivity and claimant was working approximately 50 to 60 hours a week.

In March, 1987, claimant received an outstanding work evaluation consistent with all her prior evaluations. Thereafter, however, she received three verbal warnings from her supervisor, Mr. Jern. On April 21, 1987, May 27, 1987, and May 29, 1987, Jern verbally informed claimant of mistakes in shipping and quality control. Because of these mistakes, the employer had apparently faced the unwanted prospect of repacking several shipments.

By March and April, 1987, claimant's psychiatric condition had stabilized and she exhibited no significant symptoms. Dr. Gardner anticipated that he would need to see claimant only occasionally for medication control and regulation.

On June 9, 1987, at 11:15 a.m., claimant was called to Mr. Jern's office. She did not know why Jern wished to see her. Shortly after entering Jern's office, and in the presence of Mr. Tim

Cochran, Administrative Service Manager, Jern handed claimant a written notice to read to herself. The notice informed her that she had been demoted from a Quality Control Supervisor to a Grade 3 Inspector. The demotion was to a position several levels below her supervisor position and at a $3.00 per hour reduction in pay. Claimant advised that she would not accept the demotion and requested a two-week layoff. Jern, however, informed claimant that her options were to accept the demotion or to terminate. The meeting with Jern and Cochran resulted in claimant feeling sick to her stomach. In the afternoon, claimant spoke with Mr. Renton, Plant Manager, who confirmed the same options. Claimant was given the rest of the day off to think matters over.

The next day, June 10, 1987, claimant returned to Dr. Gardner. She described the demotion incident to Gardner and indicated that she had not slept well the night before and felt betrayed by her employer. Claimant's psychological condition was depressed and sick compared to her condition in April, 1987, the date of Gardner's previous examination. Gardner diagnosed an acute post-traumatic stress disorder as a result of the shock from the demotion incident and how it was handled. Inasmuch as Gardner viewed claimant as totally disabled, he informed the employer that claimant was released from work.

Claimant did not report to the employer on June 10, 1987. Upon calling the employer on June 11, 1987, to advise that she was sick, she declined to talk to the Personnel Manager. The following day, the Personnel Manager telephoned claimant and informed her that she had been terminated effective June 10, 1987. He advised claimant to retrieve her personal belongings from the employer's premises. Although claimant repeated her desire for a layoff, the Personnel Manager denied her request.

On June 25, 1987, claimant filed an industrial claim for "extreme trauma" on "June 10, 1987 [sic]." The employer timely denied her claim.

Claimant continued to regularly treat with Dr. Gardner. By September, 1987, Gardner felt that claimant's symptoms associated with her post-traumatic stress disorder had "largely cleared," and he released her to work.

Prior to the demotion incident of June 10, 1987, some employees had complained to the employer regarding claimant's supervisory style and recent inappropriate behavior. Claimant had berated one of her inspectors in front of others on June 5, 1987, regarding that inspector's approval of the May 27, 1987, shipment. Claimant had an offensive, demanding, and military-like management style.

Due to the three shipping and quality control mistakes in April and May, 1987, Mr. Jern felt that claimant's poor work performance had to be addressed promptly and that a demotion was the best solution. The three mistakes were either directly attributable to claimant or inspectors under her supervision. Each of those mistakes were discussed with claimant at the time they occurred, including ways to avoid such mistakes in the future.

ULTIMATE FINDING OF FACT

Claimant was disabled by the stress caused by the June, 1987, demotion and termination events.

CONCLUSIONS OF LAW

Remand

The Board may remand a case to the Referee when it determines that: "[A] case has been improperly, incompletely or otherwise insufficiently developed or heard by the referee . . . ." ORS 656.295(5).

Here, we find no persuasive evidence that the record below was improperly, incompletely or insufficiently developed. The Referee allowed the employer to submit a deposition of Dr. Klein and the claimant a rebuttal report from Dr. Gardner. There was no agreement between the Referee and the parties to allow the employer to submit a medical report in reply to any further reports from Gardner. Accordingly, the Referee had discretion to close the record at that point, without the submission of further evidence.

Moreover, the parties were given the opportunity to submit written closing arguments in lieu of closing statements at the close of the hearing. They apparently chose not to. Instead, the parties gave their respective closing statements at the close of the hearing. Accordingly, we find no error in the Referee issuing his Opinion and Order, without written closing arguments from the parties.

Compensability

The Referee quoted from the case of Elwood v. SAIF, 298 Or 429 (1985), and concluded that claimant had sustained a compensable mental stress condition due to the events of June 9, 1987, and June 12, 1987. We agree with the Referee's conclusions, but not his analysis.

In Elwood, the worker presented an occupational disease claim, rather than an injury claim, for emotional stress. Therefore, at the outset, we must determine whether claimant's demotion of June 9, 1987, and/or her termination of June 12, 1987, should be characterized as an occupational disease or injury.

In Valtinson v. SAIF, 56 Or App 184, 187 (1982), the court provided, inter alia:

> "What set[s] occupational diseases apart from accidental injuries [is] both the fact that they can [not] honestly be said to be unexpected, since they [are] recognized as an inherent hazard of continued exposure to conditions of the particular employment, and the fact that they [are] gradual rather than sudden in onset.'" [quoting O'Neal v. Sisters of Providence, 22 or App 9, 16 (1975)].

The first prong of this two-part test requires a determination of whether the medical condition claimed would likely result from the work activity alleged to be the cause of the condition. The second prong requires a finding of whether the alleged medical condition was "sudden in onset."

Here, claimant was employed as Quality Control Supervisor. Unlike an occupational disease situation, she does not allege

continued exposure to stressful events that led to her mental disorder. Rather, she alleges that two discrete incidents; i.e., her June 9, 1987, demotion, and her June 12, 1987, termination, resulted in a disabling mental disorder. (See Ex. 16-1). We conclude, therefore, that claimant's job was unlikely to result in the mental disorder claimed by her. We further conclude that a period of three days, involving two discreet incidents, satisfies the "sudden in onset test" requirement. Moreover, claimant felt sick to her stomach immediately following her meeting with Mr. Jern's and Mr. Cochran on June 9, 1987. She did not sleep well that night and the next day sought treatment from Dr. Gardner. Accordingly, claimant's June, 1987, traumas are properly characterized as an industrial injury.

In injury cases, a worker must prove by a preponderance of the evidence that the industrial injury was a material contributing cause of her existing disability or need for medical services. Harris v. Albertson's Inc., 65 Or App 254 (1983); former ORS 656.005(7)(a). A worker need not, however, prove an aggravation or worsening of her underlying condition. Jameson v. SAIF, 63 Or App 553 (1983); Boise Cascade v. Wattenbarger, 63 Or App 447 (1983).

Here, claimant experienced immediate symptoms shortly after her demotion on June 9, 1987. Accordingly, she testified, inter alia:

> "Q. So what was your response when you saw that [demotion] notice?
>
> "A. I -- I couldn't believe it. I was in total shock. I mean, it just -- I was sick at my stomach and it just -- I just flat couldn't -- couldn't believe it was happening.
>
> "Q. Were you experiencing any other symptoms at that time that you remember?
>
> "A. No, I -- I just -- I just fell apart. I mean, I just -- I -- it was something I couldn't believe."

Likewise, Dr. Gardner testified as follows regarding claimant's emotional state, shortly after her demotion of June 9, 1987:

> "A. Well, I received from [claimant] at the time that she -- that -- called [i.e., June 9, 1987], wanted an appointment rather emergent fashion. She came and indicated to me that something shocking had happened at work, and that she had -- you know, she was totally unprepared for as she had been bawled out, as it were, and then let go. This was a -- something totally unexpected. She, you know -- it was real shocking. It took her apart. When I saw her in my office [i.e., June 10, 1987], she was -- had -- hadn't slept well. She was obviously quite depressed and she ultimate --- well, ultimately, she wasn't eating. She withdrew socially. She went through a lot of the symptoms of a post-traumatic stress disorder."

Moreover, there is no dispute between Dr. Gardner and Dr. Klein that claimant's symptoms were causally related to the traumas of June 9, 1987, and June 12, 1987. Rather, the only dispute is whether claimant suffered a post-traumatic stress disorder or a normal set of emotions following her demotion and eventual termination.

In Dr. Gardner's view, claimant became "truly psychiatrically ill" and unable to think clearly following her demotion of June 9, 1987. Dr. Klein, on the other hand, testified, inter alia:

> "I cannot agree with the diagnosis of post traumatic stress, because the DSM3 [i.e., the Diagnostic & Statistics Manual III] specifically rules it out in invoking that -- rules out invoking that diagnosis for ordinary life circumstances such as job reversal, marital conflict and that type of thing. And that diagnosis is reserved for very significant and unusual trauma outside of the usual scope of human experience."

Gardner did not agree with Klein, reporting, inter alia:

> "Having, of course, seen [claimant] before, during, and after, [the June, 1987, traumas] rendered my view much more accurate than Dr. Klein, who only saw [claimant] after she had achieved a position of stability, and was, in fact, psychiatrically stationary and ready to return to work. * * *.
>
> "In the diagnostic criteria for the Post Traumatic Stress Disorder in DSM III R, the requirement is that it last about one month. In my opinion, [claimant] exhibited her symptoms for 2-1/2 to 3 months, and was declared stationary and capable of returning to work in September of 1987."

We are more persuaded by the opinion of Dr. Gardner, than that of Dr. Klein. Unlike Klein, Gardner began treating claimant well before the June, 1987, traumas. He, therefore, was in a superior position to assess, first-hand, the severity of claimant's psychiatric symptoms following the traumas of June, 1987. See Weiland v. SAIF, 64 Or App 810 (1983).

Furthermore, immediately following the traumas of June, 1987, claimant sought medical attention from Dr. Gardner. Gardner noted a variety of psychiatric symptoms including, inter alia, sleeplessness, loss of appetite, and social withdrawal. Former ORS 656.005(8)(a) defines a "compensable injury" as: "[A]n accidental injury . . . arising out of and in the course of employment requiring medical services or resulting in disability or death." Claimant required Gardner's medical services for treatment of her psychiatric symptoms materially caused by the traumas of June, 1987. She has, therefore, sustained a compensable mental stress condition.

ORDER

The Referee's order, dated December 17, 1987, is affirmed. Claimant's attorney is awarded a reasonable assessed fee, payable by the insurer, of $750.

RICHARD H. OLSEN, Claimant
Darrell L. Cornelius, Claimant's Attorney
SAIF Corp Legal, Defense Attorney

WCB 87-01592
July 27, 1989
Order on Review

Reviewed by Board Members Crider and Johnson

The SAIF Corporation requests review of Referee Schultz' order that set aside its denial of claimant's occupational disease claim for hypertension. With its reply brief, SAIF submits a copy of an excerpt from a medical treatise. Claimant objects to Board consideration of this submission. On review, we decline to consider the evidentiary submission. We affirm on the merits.

ISSUES

1. Evidence. Whether, for purposes of rebutting a prior admitted exhibit, we should consider a copy of a portion of a medical report that was not offered as an exhibit at hearing?

2. Compensability. Whether work-related stress was the major contributing cause of a worsening of claimant's preexisting hypertension to the point that he required medical services or became disabled?

FINDINGS OF FACT

The Board adopts that portion of the Referee's factual findings commencing on page 1 of his order and continuing up to the first full paragraph on page 3 of his order. We make the following additional findings.

SAIF's counsel raised no objection to admission of exhibit 33 at hearing.

Work-related stress was the major contributing cause of a worsening of claimant's preexisting hypertension to the point that, on October 15, 1986, he required medical services and was disabled from work.

CONCLUSIONS OF LAW AND OPINION

Evidence

At hearing, claimant offered as an exhibit a portion of a medical treatise. Claimant's submission was admitted to the record as Exhibit 33. On Board review, SAIF asserts that the excerpted material is outdated. With its reply brief, SAIF submitted a copy of the corresponding pages from the most recent edition of the medical treatise.

We have no authority to consider evidence not admitted at the hearing and not a part of the record. Groshong v. Montgomery Ward Co., 73 Or App 403, 406 (1985). We, therefore, decline to consider SAIF's submission.

We may remand to the Referee if we find that the record

has been "improperly, incompletely or otherwise insufficiently developed." ORS 656.295(5). SAIF did not object at hearing to admission of Exhibit 33. Moreover, Dr. Bennett's opinion that the excerpt submitted by claimant at hearing was outdated was duly noted in the record. We conclude that the record has not been "improperly, incompletely or otherwise insufficiently developed." We decline to remand this matter.

Compensability

The Board adopts the Referee's opinion with regard to the merits of this case.

ORDER

The Referee's order dated January 15, 1988 is affirmed. Claimant's attorney is awarded an assessed fee of $900, to be paid by the SAIF Corporation.

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

Own Motion 87-0438M
July 27, 1989
Own Motion Order

Claimant requests that the Board exercise its "own motion" authority to reopen her claim for an alleged worsening of her May 13, 1978, industrial injury. Her aggravation rights have expired. Specifically, claimant seeks temporary disability benefits beginning on one of the following dates: (1) August 28, 1985, the date of application of a flexion jacket; (2) October 28, 1986, the date of hospitalization for chymopapaine injection treatment; and (3) June 21, 1988, the date of hospitalization for back surgery. She also seeks assessment of a penalty and attorney fee for the employer's allegedly unreasonable resistance to payment of compensation. The employer recommends the payment of temporary disability benefits beginning on the date of back surgery.

Under ORS 656.278(1)(a), we may exercise our "own motion" authority to reopen a claim 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.

By Own Motion Order dated March 25, 1987, as reconsidered on May 19 and June 24, 1987, we denied claimant's request for own motion relief based, in part, on the lack of persuasive evidence that claimant's compensable injury had worsened. After carefully reviewing this record, we remain unpersuaded that claimant's 1978 injury had worsened prior to the issuance of those orders. Accordingly, we decline to award temporary disability benefits beginning in either 1985 or 1986.

Claimant's doctor requested authorization for ba surgery in 1987. The employer denied authorization, prompting claimant to request a hearing on the denial. Ultimately, by Order on Reconsideration dated April 11, 1988, as amended on April 25 and May 11, 1988, the Board set aside the employer's denial, finding the proposed surgery to be reasonable and necessary treatment for the 1978 compensable injury. Those orders were not

appealed and, hence, are final. The surgery was later performed on June 21, 1988.

After reviewing this record, we are persuaded that claimant's 1978 compensable injury has worsened requiring hospitalization for surgery on June 21, 1988. Accordingly, claimant's claim is reopened with temporary disability benefits to commence on June 21, 1988, the date of surgery, and to continue until claimant returns to her regular work at her regular wage or is medically stationary, whichever is earlier. Reimbursement from the Reopened Claims Reserve is authorized to the extent allowed under ORS 656.625 and OAR 436, Division 45. When appropriate, the claim shall be closed by the employer pursuant to OAR 438-12-055.

On the penalty and attorney fee issue, claimant generally cites the employer's "unreasonable resistance" as the basis for the penalty and fee. However, we are not persuaded that the employer acted unreasonably in processing claimant's own motion request. Indeed, within 60 days of receiving claimant's own motion request, the employer recommended that temporary disability benefits commence on the date of her back surgery. The employer substantially complied with the Board's own motion rules. See OAR 438-12-025(2), 438-12-030(1). A penalty and attorney fee is not warranted.

As a reasonable attorney fee, claimant's attorney is awarded 25 percent of the increased compensation created by this order, not to exceed $700, payable out of compensation. Additionally, we approve a client-paid fee not to exceed $1,036.

IT IS SO ORDERED.

DAVID A. SKIPLE, Claimant
Pozzi, Wilson, et al., Claimant's Attorneys
Acker, et al., Defense Attorneys
Bullard, et al., Defense Attorneys

WCB 88-19856, 89-02402 & 89-02403
July 27, 1989
Order Denying Motion to Dismiss

Reviewed by Board Members Crider and Ferris.

Claimant has moved for an order dismissing Liberty Northwest Insurance Company's request for Board review of a Referee's order that awarded a carrier-paid attorney fee for claimant's counsel's services rendered prior to hearing in obtaining Liberty Northwest's acceptance of claimant's aggravation claim. Claimant contends that we lack jurisdiction to consider the attorney fee issue. We disagree and deny the motion.

FINDINGS OF FACT

Claimant filed an aggravation claim with Liberty Northwest and a "new injury" claim with Yellow Freight System. Eventually, both carriers denied responsibility and requested an order designating a paying agent pursuant to ORS 656.307. Thereafter, a .307 order issued, referring the matter to the Hearings Division for an arbitration proceeding.

Prior to the arbitration proceeding, with Referee approval, the parties entered into a stipulation. Liberty Northwest agreed to accept responsibility for claimant's aggravation claim. Liberty Northwest and claimant further agreed to submit the issue of claimant's entitlement to an attorney fee to the Referee for resolution.

The Referee found that claimant was entitled to a carrier-paid attorney fee for his counsel's efforts prior to the issuance of the .307 order. Consequently, the Referee awarded a carrier-paid attorney fee of $2,000, payable by Liberty Northwest to claimant. Liberty Northwest requested Board review of the Referee's order "regarding entitlement to insurer-paid attorney fees."

CONCLUSIONS

We have previously determined that we lack jurisdiction to consider requests for Board review where the sole issue is the amount of an attorney fee awarded under ORS 656.386(1). Ronald L. Warner, 40 Van Natta 1082, 1194 (1988). In such cases, the appropriate avenue of appeal is to the circuit court under the provisions of ORS 656.388(2). See Greenslitt v. City of Lake Oswego, 305 Or 530 (1988). However, we retain jurisdiction to consider issues concerning the entitlement to an attorney fee. See Betty L. Evans, 41 Van Natta 21 (1989); Ronald L. Warner, supra.

Here, the issue on review is the entitlement to, rather than the amount of, a carrier-paid attorney fee awarded by the Referee. Under such circumstances, we have jurisdiction to review the order. See Betty L. Evans, supra; Ronald L. Warner, supra.

Accordingly, the motion to dismiss is denied. Once a hearing transcript is obtained, copies will be provided to the parties and a briefing schedule implemented. Upon completion of the briefing schedule, this case will be docketed for Board review.

IT IS SO ORDERED.

THEODORE R. STOLLER, Claimant
Lawrence A. Castle, Claimant's Attorney
Ridgeway K. Foley, Defense Attorney
David O. Horne, Defense Attorney

WCB 87-07972
July 27, 1989
Order on Review

Reviewed by Board Members Crider and Johnson.

Wausau Insurance Company ("Wausau") requests review of those portions of Referee Higashi's order that: (1) set aside its aggravation denial of claimant's low back condition; and (2) upheld St. Paul Fire & Marine Insurance Company's ("St. Paul") "new injury" denial, of the same condition.

The Board affirms the order of the Referee.

ISSUES

1. Whether claimant sustained a compensable aggravation or "new injury."

2. Whether Wausau or St. Paul is responsible for claimant's current low back condition.

FINDINGS OF FACT

The Board adopts the Referee's findings and makes the following additional findings.

Although claimant's low back pain diminished following his compensable injury of October, 1984, it never completely resolved.

While at home, claimant regularly hauled firewood from an outside shed into his house. He usually carried six-to-eight pieces of wood. His house was apparently heated by a wood burning stove, which necessitated the firewood hauling. No incident or back pain occurred while claimant was lifting or hauling firewood.

In early March, 1987, claimant contracted a chest cold that eventually resulted in episodic coughing. While coughing on Saturday, March 7, 1987, his back went "out." He felt spasms and pain in his low back and into his left leg. Such symptoms were identical to those he sustained following his compensable injury of October, 1984, only more severe. The following day, he telephoned Mr. Childs, his assistant supervisor, and informed him that he would be unable to work on Monday, March 9, 1987. Following Childs' advice, claimant telephoned his production supervisor, "Cy," on March 9, 1987, to report that he was unable to work.

Claimant returned to Dr. Schmidt, his treating chiropractor, on March 11, 1987. Schmidt diagnosed a low back strain with attendant spasm and took claimant off work for five and one-half weeks.

On March 16, 1987, Mr. Hoffstetter, the owner of St. Paul's insured, telephoned claimant. Claimant informed Hoffstetter that he would be ready to return to work in eight weeks. Some discussion of the cause of claimant's back problem took place during this telephone conversation. There was no discussion nor mention, however, of any incident or injury associated with claimant's firewood hauling.

ULTIMATE FINDINGS OF FACT

Claimant's industrial slip-and-fall injury of February 2, 1987, did not independently contribute to cause a worsening of his underlying low back condition.

Claimant's compensable low back injury of October 10, 1984, his industrial slip-and-fall incident of February 2, 1987, his at-home firewood hauling, and his at-home coughing episode of March 7, 1987, all contributed to cause a worsening of his low back symptoms and disability.

CONCLUSIONS OF LAW

We agree with the Referee's conclusion that claimant sustained an aggravation, rather than a "new injury", however, inasmuch as his order issued before the Court of Appeals' decision on remand in Gwynn v. SAIF, 304 OR 345, on rem 91 Or App 84 (1988), we do so under our own analysis.

Compensability

In compensability/responsibility cases, as here, the threshold issue is compensability. To establish a compensable aggravation, claimant must prove, inter alia, that his increased low back pain in March, 1987, was greater than that contemplated at the time of his last arrangement of compensation. Gwynn v. SAIF, supra. Inasmuch as claimant sustained a nondisabling

compensable injury, we find that the Notice of Closure, dated October 5, 1985, did not contemplate future symptomatic flare-ups. Accordingly, we conclude that claimant's increased low back pain in March, 1987, which resulted in five and one-half weeks of total disability, caused a worsening of his compensable injury.

Turning to the element of causation, see Stepp v. SAIF, 78 Or App 438, 441 (1986) and ORS 656.273(1), claimant must prove that his compensable injury materially contributed to his worsened condition. As we understand the uncontradicted testimony of Dr. Schmidt, claimant's treating chiropractor, he is of the opinion that several factors contributed to claimant's worsened condition. Those factors include: (1) the progression of the compensable injury of October, 1984; (2) the industrial slip-and-fall incident of February 2, 1987; (3) the at-home firewood hauling; and (4) the at-home coughing episode of March 7, 1987. (Ex. 12 pp. 17-19).

When both on-the-job and off-the-job factors contribute to a worker's worsened condition, as here, it is well settled that he has proven a material causal contribution. Grable v. Weyerhauser, 291 Or 387 (1981). Accordingly, we conclude that claimant has proven a material causal relationship between his worsened condition and the compensable injury of October, 1984.

We further conclude that claimant has proven the compensability of his February 2, 1987, slip-and-fall injury. The injury was witnessed by co-worker, Mr. Mize, who testified, inter alia: "I saw [claimant] go down." (Tr. 31). Moreover, as we found above, the uncontradicted testimony of Dr. Schmidt is that the slip-and-fall injury contributed to claimant's worsened condition, which required medical services and resulted in disability. See ORS 656.005(7)(a).

Responsibility

Responsibility remains with Wausau, unless the "new injury" independently contributed to claimant's disability (i.e., caused a worsening of his underlying condition). Hensel Phelps Construction v. Mirich, 81 Or App 290, 294 (1986).

The evidence suggests that claimant's slip-and-fall injury of February 2, 1987, did not independently contribute to a worsening of his underlying low back condition. In fact, claimant felt that his back was "fine" immediately after the slip-and-fall. He took no time off work. Moreover, on March 11, 1987, Dr. Schmidt opined that claimant's symptoms were "nearly identical" to those he had experienced following his compensable injury of October, 1984.

Under such circumstances, we agree with the Referee's conclusion that claimant sustained an aggravation, rather than a "new injury."

ORDER

The Referee's order, dated November 30, 1987, is affirmed. Claimant's attorney is awarded an assessed fee of $1000, to be paid by Wausau. The Board approves a client-paid fee, payable from St. Paul to its attorney, not to exceed $856.

LENNY G. TAYLOR, Claimant
Max Rae, Claimant's Attorney
Merrily McCabe (SAIF), Defense Attorney

WCB 87-15293
July 27, 1989
Order on Review

Reviewed by Board Members Crider and Ferris

Claimant requests review of Referee Hettle's order that upheld the SAIF Corporation's denial of medical services related to his current neck, low back, and bilateral leg, foot and hand conditions. On review, the sole issue is whether claimant's current need for treatment is materially related to his compensable injury with SAIF.

We affirm.

FINDINGS OF FACT

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

The Referee found that "[w]ith regard to claimant's cervical problems, Dr. Peterson diagnosed degenerative joint disease, spondylosis at the L5 level . . . " We, instead, find that Dr. Peterson diagnosed slight spondylosis at the C5 level.

The Referee found that claimant first treated for cervical problems in December 1981, whereas we find that claimant first treated for his neck problems in October 1981.

The Referee found that claimant sought no additional treatment after June 1983 for approximately three years, whereas we find that claimant did not seek further treatment for almost four years.

We make the following additional findings of fact.

Claimant was a credible witness, but he had a poor memory regarding the onset of his leg, foot, hand and neck symptoms.

Claimant experienced low back pain and tingling and pain in both legs following his January 1979 injury. Claimant developed leg jerking and foot and hand pain in or around August 1981, followed by the onset of neck pain in or around October 1981.

FINDINGS OF ULTIMATE FACT

Claimant has not demonstrated that his current need for medical treatment is related to his compensable injury in 1979.

CONCLUSIONS OF LAW AND OPINION

We adopt the Referee's opinion subject to the following comment.

Low Back Condition and Related Bilateral Leg Pain

Claimant suffers from low back and bilateral leg pain. The medical experts attribute these symptoms to degenerative changes in claimant's lumbar spine. The Referee concluded that

claimant had not demonstrated that his current low back symptoms are causally related to his compensable injury in 1979. The Referee did not specifically address claimant's related bilateral leg pain.

We do not entirely agree with the Referee's evaluation of the medical evidence regarding claimant's low back condition. Treating chiropractor Whitmore rendered an opinion supporting a causal relationship between claimant's compensable injury in January 1979 and his current low back problems. The Referee declined to afford that opinion any special weight based on his finding that Whitmore "never treated claimant before April 1987." However, claimant credibly testified that Dr. Whitmore was involved in his initial treatment at the Whitmore clinic in 1981. Accordingly, Dr. Whitmore is entitled to some deference as claimant's treating physician.

Nevertheless, we agree with the Referee's ultimate conclusion that claimant has not demonstrated that his current low back condition is causally related to his compensable injury in 1979. The first persuasive, objective evidence of lumbar disc damage is provided by x-rays taken in 1987, more than eight years after the compensable injury. We recognize that neurosurgeon Tsai diagnosed a possible herniated disc when he examined claimant in September 1981. We are also aware that treating chiropractor Hazen opined that x-rays taken in 1981 demonstrated "trouble with L4-5 and L5-S1 disc spaces." However, these and subsequent lumbar x-rays taken in 1981 were interpreted as normal by no fewer than four physicians with special expertise in reading spinal x-rays and diagnosing spinal conditions, including Dr. Tsai, himself. Moreover, Dr. Tsai, while noting that the 1979 fall preceded the x-ray observations, did not relate any disc abnormality to the compensable injury.

Furthermore, there is no persuasive medical opinion linking claimant's current back condition to his 1979 injury. We recognize that claimant's current treating chiropractor, Dr. Whitmore, attributed his low back pain to that injury. However, the Referee concluded that his opinion was not persuasive, and we agree. Dr. Whitmore based his opinion entirely on the fact that claimant had complained of pain in the same area of the low back following his 1979 injury. He did not address other possible alternative causes, such as the natural aging process and claimant's strenuous work and personal activities. In light of these weaknesses, the Referee correctly concluded that Dr. Whitmore's opinion is entitled to little weight.

Accordingly, we agree with the Referee's conclusion that claimant has not demonstrated that his current low back pain is compensable. For the same reasons, we conclude that claimant's bilateral leg pain is not compensable.

Leg Jerking and Neck, Hand and Foot Pain

We agree with the Referee's position that expert medical opinion was required to demonstrate claimant's entitlement to medical services for his leg jerking and hand, foot and neck problems. The record contains contrary opinions from a number of medical experts, who identify possible alternative causes for these conditions. Moreover, the first documented complaints of these problems occurred in August and October 1981, more than

18 months after the January 1979 injury. Claimant suggested that he began experiencing these problems as early as April 1981, but we defer to the documented medical record in light of his poor memory regarding the onset of his various symptoms. Given this record, the causation issue in this case is a complex medical question requiring expert medical opinion.

In regard to claimant's foot pain, the Referee concluded that the record contained no medical evidence relating that problem to his compensable injury. The Referee apparently overlooked chiropractor Hazen's August 1981 first medical report in which he checked the "work-related" box and listed foot pain among claimant's complaints. Nevertheless, we agree with the Referee's ultimate conclusion that claimant has not demonstrated a compensable foot condition. Dr. Hazen's August 1981 report apparently related claimant's foot problem to his low back condition, and claimant has not demonstrated that the latter condition is compensable.

Finally, we agree with the Referee's conclusion that the record contains no persuasive medical opinion relating claimant's neck problems to his compensable injury. The Referee gave little weight to the December 1981 comment of former treating chiropractor Hazen that "[n]eck pain is a common sequel to low back problems." This comment is irrelevant in light of our conclusion that claimant has not demonstrated that his low back problems are compensable.

ORDER

The Referee's order dated February 4, 1988 is affirmed.

DANELL L. SWEISBERGER, Claimant
James L. Francesconi, Claimant's Attorney
Michael Bostwick, Defense Attorney

WCB 87-00308
July 27, 1989
Order on Review

Reviewed by Board Members Ferris and Johnson.

Claimant requests review of that portion of Referee Podnar's order that found that claimant's low back injury claim was not prematurely closed. On review, the sole issue is premature claim closure. We affirm.

FINDINGS OF FACT

On November 11, 1983, claimant, a 42 year old keypunch operator, injured her low back when she slipped while moving a full box of computer paper. On August 13, 1984, Dr. Brett, neurological surgeon, performed a right L4-5 lumbar discectomy and removal of sequestrated fragment. Following surgery, claimant's leg pain resolved, but her low back pain continued. In December 1985, claimant's vocational assistance was terminated due to her lack of participation in job search. In February 1986, diagnostic testing, including x-rays, a myelogram, and a limited bone scan, failed to reveal any abnormalities.

In March 1986, Dr. Brett discharged claimant to Drs. Parent and Lee for control of her chronic pain syndrome. At that time, Dr. Brett diagnosed an anular pain syndrome aggravated by poor posture, obesity, and emotional overlay.

In April 1986, claimant sustained a compensable aggravation of her industrial injury. Claimant was examined by Dr. Utterback who diagnosed: (1) status post-operative herniated nucleus pulposis at L4-5; (2) right greater trochanteric tendinitis; (3) obesity; and (4) a low pain threshold.

In May 1986, Dr. Klein, psychiatrist, examined claimant. She found her to be quite overfocused on her physical problems and entrenched in a disabled role. Dr. Klein recommended claim closure based on objective medical data.

Dr. Lee's medical treatment for claimant's myofascial pain syndrome included acupuncture therapy. On August 20, 1986, Dr. Lee reported that the last needle procedure had been performed on July 25, 1986. He stated that he would recheck claimant in two to three months and reevaluate her need for further treatment at that time.

On September 22, 1986, claimant was involved in a motor vehicle accident. Her neck and right shoulder were involved. Her low back condition was not worsened by the accident; moreover, her low back condition has not changed since that time. Medical treatment following the motor vehicle accident was concentrated on the effects of the auto accident and not the low back.

On November 14, 1986, the Orthopaedic Consultants examined claimant. They found that significant psychological factors were interfering with her recovery. The severe functional disturbance was characterized by many inconsistencies during examination and resistance against movement, as well as other forms of pain behavior. They recommended that claimant's pool therapy and acupuncture treatments be terminated.

On December 12, 1986, claimant entered into a Stipulation and Disputed Claim Settlement, whereby the insurer agreed to reopen claimant's low back claim retroactive to April 1986. In addition, in exchange for a sum of money, claimant agreed that her psychiatric condition and need for weight loss treatment were not compensable.

On December 19, 1986, Dr. Lee outlined an acupuncture treatment plan to reduce claimant's lumbosacral paraspinal pain.

On January 2, 1987, Dr. Lee asserted that he did not agree with that aspect of the Orthopaedic Consultants' November 14, 1986 report which failed to diagnose a myofascial pain syndrome.

On March 12, 1987, a Determination Order closed, finding claimant stationary as of November 14, 1986.

Claimant was neither employed nor seeking work at the time of hearing because of severe headaches she was experiencing since the motor vehicle accident.

At the time of claim closure, no further material improvement of claimant's compensable low back condition was reasonably expected from medical treatment, or the passage of time.

CONCLUSIONS OF LAW

The Referee relied upon the opinion of the Orthopaedic Consultants and concluded that claimant's claim was not prematurely closed. We agree.

Claims shall not be closed nor temporary disability compensation terminated if the worker's condition has not become medically stationary. ORS 656.268(1). An injured worker will be considered medically stationary when no further material improvement of the compensable condition would reasonably be expected from medical treatment, or the passage of time. ORS 656.005(17).

It is claimant's burden to establish that she was not medically stationary when the claim was closed. Brad T. Gribble, 37 Van Natta 92 (1985). The resolution of the medically stationary date is primarily a medical question based on competent medical evidence. Harmon v. SAIF, 54 Or App 121, 125 (1985). Changes in claimant's condition which occur subsequent to the date of closure are not to be considered in determining whether a claim was prematurely closed. Scheuning v. J.R. Simplot & Co., 84 Or App 622, 625 (1987).

In August 1986, Dr. Lee indicated that the last acupuncture treatment had been performed on July 25, 1986. He stated that he would recheck claimant in two to three months and reevaluate her need for further treatment at that time. On December 22, 1986, he recommended 12 more weeks of acupuncture, on a three times per week basis.

On November 14, 1986, the Orthopaedic Consultants examined claimant and opined that claimant's low back condition was medically stationary. They explained that:

> "In this lady we see subjective symptoms that are far out of proportion to what is actually found on an objective basis. We think that continued treatment of her lower back will not bring about any improvement but that it will, in fact, tend to reinforce her back illness and increase her focus upon the back and the back symptoms. We would strongly urge that no further treatment be carried out in relation to the lower back and that claim closure be carried out now."

Dr. Lee responded to the Orthopaedic Consultants' November report by authoring two reports which discussed his difference of opinion with their failure to diagnose claimant's myofascial pain syndrome. In neither of Dr. Lee's reports, however, did he disagree with the Consultants' assertion that claimant's condition was medically stationary. The only indication from Dr. Lee that claimant was not medically stationary appeared in the December 19, 1986 Treatment Plan, in which he stated that the objective of continued acupuncture treatment was to reduce pain in the lumbosacral paraspinal area.

Yet, the treatment plan notwithstanding, Dr. Lee provided no treatment for claimant's low back condition after the

September 1986 motor vehicle accident. In addition, there is no indication that, after June 1986, claimant's condition was improving. Finally, we are persuaded by the Orthopaedic Consultants' opinion that the acupuncture treatments would not improve claimant's condition.

Consequently, we conclude that, at the time of claim closure, no further material improvement in claimant's compensable condition was reasonably expected from medical treatment or the passage of time. Accordingly, we agree with the Referee that the claim was not prematurely closed.

ORDER

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

HARRY W. HAYES, Claimant
Malagon, et al., Claimant's Attorneys
E. Jay Perry, Defense Attorney
Schwabe, et al., Defense Attorneys
SAIF Corp Legal, Defense Attorney

Own Motion 89-0411M
July 31, 1989
Own Motion Order
Consent to Issuance of Order Designating a Paying Agent (ORS 656.307)

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

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

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

ALFREDO G. BUSTAMANTE, Claimant
Brian Whitehead, Claimant's Attorney
SAIF Corp, Insurance Carrier

WCB 89-0438M
August 7, 1989
Denial of Consent to Issuance of Order Designating a Paying Agent (ORS 656.307)

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

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

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

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

LORI G. FINCH, Claimant
Emmons, Kyle, et al., Claimant's Attorneys
Rankin, et al., Defense Attorneys
Schwabe, et al., Defense Attorneys
Roberts, et al., Defense Attorneys

WCB 83-03809, 85-00155 & 85-13714
August 8, 1989
Order on Remand

Reviewed by Board Members Crider and Ferris.

This matter is before the Board on remand from the court of Appeals. Finch v. Stayton Canning Co., 93 Or App 168 (1988). In our order on review dated November 4, 1986, we, inter alia, affirmed those portions of the Referee's order that: (1) upheld the three denials of compensability/responsibility; and (2) declined to assess a penalty for the late denial by National Surety Corporation, the insurer for Tom's Auto Body (Tom's). The Finch court reversed the Board on the issue of compensability and remanded to determine the issues of responsibility and penalties. In addition, Tom's has preserved its contention that the claim is time-barred. On remand, we address these issues.

ISSUES

1. Whether claimant's claim against Tom's is time-barred.

2. The responsible insurer for claimant's current left carpal tunnel syndrome.

3. Whether Tom's should be assessed a penalty for its late denial.

FINDINGS OF FACT

The Board adopts the Court of Appeals findings in Finch, supra, and makes the following additional findings.

In November, 1982, claimant worked 13 days for Stayton Canning Company (Stayton), a self-insured employer. After a few days on the job, she developed left wrist pain, but did not seek medical attention. Shortly thereafter, she began working for Dave's US Gas (Dave's), insured by American States Insurance Company. Her left wrist pain continued. On February 1, 1983, she consulted Dr. Ellison, a hand specialist. Ellison noted, inter alia: "She [claimant] may have ulnar nerve irritation . . . ." The next day, claimant filed an industrial claim for a "strain / left wrist" against Stayton.

In July, 1983, claimant discontinued her employment at Dave's and briefly moved to California. In November, 1983, she returned to Oregon and began working for Tom's. She worked at Tom's until February, 1984.

On June 7, 1984, Dr. Ellison signed a report indicating that claimant's work activities at Dave's were the major contributing cause of her left carpal tunnel syndrome. At that time, claimant had not informed Ellison of her work activities at Tom's. (Exs. 6, 17-4 & 17-37). In August, 1984, claimant filed an industrial claim against Dave's for "swelling in [left] wrist."

Claimant was examined by Dr. Steele, an orthopedic surgeon, in September, 1984. During her examination, she informed Steele that her left wrist pain had not improved over the last year and one-half. She further informed Steele that her pain usually subsided in the evenings, depending on the amount of work she did during the day. Steele diagnosed, "[p]robable left carpal tunnel syndrome." In November, 1984, she returned to Steele. At that time, she informed Steele that her left wrist pain had improved with avoidance of repetitious work, such as at Stayton. She never informed Steele of her employment at Tom's. (Ex. 19).

Claimant's industrial claims were denied by both Stayton and Dave's. She appealed and a hearing convened in June, 1985. At the beginning of the hearing, Stayton's attorney objected to an apparent motion by claimant's attorney to keep the record open for the deposition of Dr. Ellison. (Tr. 3). At the close of the hearing, the Referee overruled Stayton's attorney's objection. (Tr. 65). A few days later, claimant's attorney deposed Ellison. (Tr. 17).

On July 3, 1985, claimant apparently filed an industrial claim against Tom's. (Record at 66). Tom's did not deny that claim until December 17, 1985.

Thereafter, claimant's attorney moved to join Tom's as a party defendant. The Referee granted claimant's motion. (Record at 65). In its amended responsive pleading, Tom's filed a response alleging that claimant had not filed a timely claim.

Claimant was employed full time at Bill's Flower Tree from January, 1985, through the date of the second hearing in February, 1986.

ULTIMATE FINDINGS OF FACT

Claimant was was not informed by a physician that she had an occupational disease in connection with her employment at Tom's, until Dr. Ellison's deposition of June 13, 1985.

Claimant's employments at Stayton, Dave's, and Tom's required repetitious use of her hands and wrists. She first sought medical treatment for her disease, diagnosed as left carpal tunnel syndrome, on February 1, 1983. Several months later, she began working for Tom's. Her employment at both Dave's and Tom's independently contributed to the permanent worsening of her disability and underlying disease.

CONCLUSIONS OF LAW

Timeliness

At the outset, we note that although counsel for Tom's specifically raised the defense of timeliness prior to the hearing, neither the Referee, the Board, nor the court have addressed that issue. In remanding this case to the Board, the court observed that Tom's continued to assert that "the claim against it was untimely." Accordingly, we conclude that we should address the timeliness issue on remand.

Former ORS 656.807(1), the statute in effect at the time claimant filed her July, 1985, claim against Tom's, provides:

> "Except as otherwise limited * * * all occupational disease claims shall be void unless a claim is filed with the insurer or self-insured employer within five years after the last exposure in employment subject to the Workers' Compensation Law and within 180 days from the date the claimant becomes disabled or is informed by a physician that the claimant is suffering from an occupational disease, whichever is later."

Here, regardless of the date of disability, claimant was not informed by a physician that she suffered from an occupational disease with respect to her work activities at Tom's, until Dr. Ellison's deposition of June 13, 1985. If she became disabled prior to that date, pursuant to former ORS 656.807(1), supra, she had 180 days from June 13, 1985, to file her claim against Tom's. She did so; she filed by July 3, 1985. If, on the other hand, she became disabled some time after June 13, 1985, the 180-day period would not begin to run until that date of disability. In either event, her claim against Tom's is timely. We, therefore, need not decide the date of disability, if any, for the purposes of resolving the timeliness issue.

Responsibility

In the occupational disease context, as here, the last injurious exposure rule ("the rule") is this:

> "[I]f a disease is contracted and disability occurs during one employment as a result of conditions of that employment, even though work conditions of a later employment could have caused that disease, the earlier employer is liable if the later employment 'did not contribute to the cause of, aggravate, or exacerbate the underlying disease. Bracke [v. Baza'r, Inc., 293 Or 239 (1982)] is such a case.'" Boise Cascade Corp. v. Starbuck, 296 Or 238 (1984). (Emphasis added).

As can be seen above, correct application of the rule requires the fact finder to initially determine the date in which the worker became disabled. See former ORS 656.005(8)(b) & (9). If the worker has not become disabled by the disease, as here, the fact finder must look to the date the worker first received medical services for her disease. Bracke, 293 Or at 248, n. 4 (1982); United Pacific Insurance Co. v. Harris, 63 Or App 256, 260, rev den 295 Or 730 (1983). Here, claimant first sought medical services for her disease on February 1, 1983; i.e., the date she initially consulted Dr. Ellison. At that time, she was employed by Dave's and, thereafter, by Tom's.

Having found above that claimant first sought medical services for her disease while employed at Dave's, we turn to whether her later employment at Tom's contributed to her underlying disease such that responsibility may shift. The court has concluded that it did, saying,

> "We agree with the Board that the medical evidence in this record--and it is principally [Dr.] Ellison's extensive testimony--establishes that claimant's carpal tunnel syndrome was an occupational disease that her work at Stayton caused and that her employment both at Dave's and Tom's permanently worsened." 93 Or App at 172. (Emphasis added).

The court further found that claimant's "work activities at both Dave's and Tom's worsened the underlying condition." 93 Or App at 174.

Accordingly, we conclude that Tom's is responsible for claimant's left carpal tunnel syndrome.

Penalties

After receiving notice or knowledge of a claim, an employer has 60 days to issue a written acceptance or denial. ORS 656.262(6). Here, Tom's denied claimant's claim well after the expiration of the 60-day period. In our prior order, we found that Tom's unreasonably delayed denying claimant's claim, but we assessed only an attorney fee, not a penalty, because there were no "amounts then due." See ORS 656.262(10).

Here, the Finch court has found that claimant established a compensable claim for her left carpal tunnel syndrome. We have found above that Tom's is responsible for her disability.

Nevertheless, there were no amounts due at the time of the denial against which a penalty may be assessed. As far as we are aware, claimant has presented no evidence of entitlement to interim compensation. ORS 656.262(4). That is, at the time she filed her claim against Tom's she was employed full time and remained so through the date of Tom's denial. (June 5, 1985, Tr. at 23). Bono v. SAIF, 298 Or 405 (1984). Furthermore, pending acceptance or denial, unpaid medical bills are not compensation payable to claimant. ORS 656.262(6).

Accordingly, we continue to find that the assessment of a penalty is not appropriate.

ORDER

National Surety Corporation's (National) denial, dated December 17, 1985, is set aside and the claim is remanded to National for processing according to Law. Claimant's attorney is awarded a reasonable assessed fee of $7,050, for services before every forum to be paid by National. The Board approves a client-paid fee, payable from American States Insurance to its attorney, not to exceed $1,574. The Board approves a client-paid fee, payable from Stayton Canning Company to its attorney, not to exceed $229.50. The Board approves a client-paid fee, payable from National to its attorney, not to exceed $520.

ROBERT D. SURINA, Claimant
Rodney Kirkpatrick, Claimant's Attorney
Randy G. Rice, Defense Attorney

WCB 86-15896
August 8, 1989
Order on Review

Reviewed by Board Members Crider and Ferris.

Claimant requests review of Referee Knapp's order that: (1) declined to grant permanent total disability; and (2) affirmed a Determination Order that awarded 40 percent (128 degrees) unscheduled permanent disability for a back injury. The issue on review is entitlement to permanent total disability benefits. We affirm.

FINDINGS OF FACT

Claimant, 54 years of age at hearing, has been employed for approximately 20 years as a health care administrator. He has also been employed during this time as a part-time college instructor in the areas of management training and human relation communications. He has a college degree in education and a master's degree in human resource development with some credits toward a doctorate.

In 1980, claimant became employed as administrator for the employer's nursing home. On January 23, 1983, claimant compensably injured his back while lifting cases of canned goods. The incident resulted in a disk herniation which caused low back and left leg symptoms. Dr. Berkeley, neurosurgeon, became claimant's treating physician. In February 1983, he performed an L4-5 laminectomy and microdiscectomy.

Claimant returned to work. However, he experienced a recurrence of the prolapsed disc and, in May 1983, Dr. Berkeley performed a second L4-5 discectomy. Claimant again returned to work but resigned in November 1983 at the request of the employer.

Claimant experienced another recurrence of the prolapsed disc in December 1983. He underwent further surgery at that time involving excision of additional disc material, nerve decompression and scar removal. Claimant experienced some improvement of his symptoms following this surgery.

However, in March 1984, claimant's back and leg symptoms increased. In June 1984, Dr. Berkeley peformed additional surgery. This surgery was at the L5-S1 level.

In February 1985, claimant suffered a heart attack. Bypass surgery was performed in March 1985. Claimant experiences occasional nondisabling chest pain. This heart condition was neither caused nor worsened by claimant's compensable 1983 injury.

In December 1985, claimant was admitted to the hospital for severe shortness of breath with any exertion.

Claimant was again admitted to the hospital in August 1986 due to acute shortness of breath.

Claimant's claim was closed by a November 6, 1986 Determination Order that awarded 40 percent unscheduled permanent disability.

Claimant has constant low back pain that increases with increased activity. He also experiences left leg and foot pain and numbness. In addition, he suffers from intermittent left foot drop which has caused him to fall multiple times. His pain increases with sleeping on his right side and interferes with his sleep. Claimant can walk up to four blocks, but he experiences shortness of breath and increased back and leg symptoms if he does so. Claimant can sit for up to one hour at a time. He is able to drive for 30 to 45 minutes. He avoids stairs if possible. He has used a cane and wheelchair because of his low back and leg symptoms.

In addition, claimant suffers from preexisting hypertension. This condition is not disabling. Claimant also suffers from chronic obstructive pulmonary disease. This pulmonary condition preexisted claimant's compensable 1983 injury. Although it caused shortness of breath, but was not disabling prior to that time, it did not interfere with claimant's regular regimen of vigorous physical activity or with his work. Since the 1983 injury, worsening of the pulmonary condition has resulted in periods of total disability. This worsening is unrelated to the compensable 1983 injury.

Claimant is limited to sedentary activities as a result of his 1983 injury and the worsening of his respiratory condition. Employment as a health care administrator is sedentary. The work can be performed from a wheelchair. Claimant has not looked for employment since leaving his job in November 1983. However, he has received a number of unsolicited employment

offers in his field. He has turned these offers down based upon his physical condition.

We are unable to find that claimant is permanently and totally disabled from regularly performing gainful and suitable work as a result of his compensable 1983 injury.

CONCLUSIONS OF LAW AND OPINION

The Board adopts the Referee's Opinion with the following supplementation.

Claimant contends that he is unable to return to regular gainful employment due solely to his compensable low back, leg and foot symptoms. Claimant argues in this regard that his heart condition and his chronic obstructive pulmonary disease do not limit his ability to perform the duties of either an administrator or a college instructor. We are not so persuaded.

When claimant was admitted to the hospital in December 1985, he reported that he barely left his home, primarily because of shortness of breath with any exertion. Upon his hospital admission in August 1986, claimant reported that he had experienced 8 to 10 prior hospital admissions for exacerbation of his respiratory difficulties. He reported that he could walk for approximately four blocks before he became so short of breath that he had to stop. He also reported that as mild an exertion as toweling himself off following a shower or carrying a bag of groceries resulted in shortness of breath. In addition, claimant reported that he had retired from his work because of his pulmonary difficulties. Moreover, in September 1986, Dr. Berkeley reported that claimant was unable even to walk out of his house because of his severe respiratory problems.

Claimant's testimony at hearing was notably different. At hearing, claimant testified that his inability to walk more than four blocks was due to his back injury. He testified that his inability to lift objects was also due to his back injury. He related his inability to perform his administrative duties solely to his back problems. He attributed his home confinement strictly to his back condition. In this regard, he denied that his respiratory problems had reached the point in September 1986 that he could not walk outside his home.

We are unable to reconcile the inconsistencies in claimant's testimony with his prior statements to medical care providers. We are more persuaded by claimant's prior statements made in conjunction with the receipt of medical treatment than we are persuaded by his testimony at the hearing to determine the extent of his compensable disability. Moreover, claimant's inconsistent statements reduce the persuasiveness of Dr. Berkeley's opinions which necessarily rely upon the accuracy of claimant's history and subjective reports. See Frank E. Battaglia, 40 Van Natta 842 (1988).

In summary, we conclude that claimant's current disability is caused, in part, by his chronic respiratory difficulties. These difficulties preexisted his 1983 injury. However, there is no persuasive evidence that his respiratory problems were disabling prior to the compensable injury. In addition, the record is devoid of evidence that the 1983 injury

caused his respiratory condition to worsen to the point that it became disabling in 1985. Accordingly, the condition is not considered in determining claimant's entitlement to permanent total disability benefits. See ORS 656.206(1)(a); Walter R. Searles, 41 Van Natta 627, 629 (1989).

We are, therefore, left to speculate as to the degree to which claimant's noncompensable respiratory condition contributes to his overall disability. For this reason, as well as those expressed by the Referee, we conclude that claimant has failed to sustain his burden of proving entitlement to permanent total disability benefits.

ORDER

The Referee's order dated October 1, 1987 is affirmed.

SUZANNE S. WILSON, Claimant
James W. Powers, Claimant's Attorney
Brian L. Pocock, Defense Attorney

Own Motion 87-0393M
August 8, 1989
Own Motion Order

Claimant initially requested in July, 1987, that the Board exercise its own motion authority to reopen her claim for an alleged worsening of her June 7, 1978, industrial injury with Aetna. However, in November, 1987, the insurer denied responsibility for claimant's condition and associated surgery. Claimant requested a hearing on that denial. Consequently, the Board postponed further action on the own motion case until resolution of that hearing. After the hearing, Referee Howell issued his Opinion and Order, holding that Aetna was responsible for claimant's condition and surgery. That order was not appealed and is final by operation of law. Hence, we now address the own motion case. Claimant's aggravation rights have expired.

Claimant seeks the following relief: (1) reimbursement for out-of-pocket medical and transportation costs incurred before and after the hearing before Referee Howell; (2) a penalty and attorney fee for the insurer's alleged failure to provide timely discovery; (3) a penalty and attorney fee for the insurer's alleged delay in deposing a doctor following the hearing; (4) claim reopening for her allegedly worsened condition; (5) temporary disability benefits from March 2, 1987, to August 21, 1987, and from February 25, 1988, to March 8, 1988; (6) claim closure with a new permanent disability award; and (7) a penalty and attorney fee for the insurer's allegedly unreasonable delay in responding to claimant's initial request for own motion relief. The insurer contends that most of the above issues should have been raised at hearing before Referee Howell.

As enumerated above, issues 1, 2, and 3 do not concern matters within the scope of our own motion authority. Rather, they are hearings issues that should have been raised either before Referee Howell or by a separate hearing request. Therefore, we only address the four remaining issues.

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

worker is actually hospitalized or undergoes outpatient surgery. Claimant contends that this matter should not be processed under the current own motion law, but rather under the law in effect at the time she made her request for own motion relief in 1987. We previously rejected that contention in Orville D. Shipman, 40 Van Natta 537 (1988), and Andy Webb, 40 Van Natta 586 (1988). Applying the current law, we are persuaded that claimant's compensable injury has worsened, requiring surgery on May 20, 1987. Accordingly, we reopen claimant's claim for temporary disability benefits to commence on May 20, 1987, the date of hospitalization for surgery, and to continue until claimant returns to her regular work at her regular wage or is medically stationary, whichever is earlier. Reimbursement from the Reopened Claims Reserve is authorized to the extent allowed under ORS 656.625 and OAR 436, Division 45. When appropriate, the claim shall be closed by the insurer pursuant to OAR 438-12-055.

Due to the current statutory limitation on our own motion authority, we decline to grant temporary disability benefits for any period prior to the date of claimant's actual hospitalization on May 20, 1987, and we decline to consider claimant's possible entitlement to compensation for permanent disability.

With regard to the final issue of a penalty and attorney fee for the insurer's allegedly unreasonable delay in responding to claimant's initial request for own motion relief, we evaluate the reasonableness of the insurer's conduct under the own motion rules in effect at the time of claimant's request, i.e., July, 1987. The Board's own motion rules in effect at that time directed that the insurer advise the Board of its position regarding claimant's request within 20 days of receipt. Former OAR 438-12-005(1)(c). Claimant's initial own motion request was received in this office on July 7, 1987. The Board asked the insurer for its response on July 20, August 27 and December 3, 1987. On December 22, 1987 the insurer sent the Board a copy of its denial of responsibility for claimant's condition and associated surgery, and the Board then issued the order postponing action on the own motion request. The insurer's five-month delay violated the Board's rules for the proper and expeditious disposition of own motion requests. That violation was significant and unexplained. We find, therefore, that the insurer ultimately and unreasonably delayed the payment of temporary disability compensation to claimant. Accordingly, we assess a penalty in the amount of 25 percent of temporary disability benefits awarded by this order. See ORS 656.262(10); Eastmoreland Hospital v. Reeves, 94 Or App 698, 702; Paul Jackson, 41 Van Natta 558, recon 41 Van Natta 822 (1989). An insurer-paid attorney fee of $500 is also assessed for the insurer's unreasonable delay. See ORS 656.262(10), 656.382(1); Eastmoreland Hospital v. Reeves, supra. In addition, claimant's attorney is awarded 25 percent of the additional compensation granted by this order, not to exceed $500, as a reasonable attorney fee.

IT IS SO ORDERED.

DAVID T. CARTER, Claimant
Doblie & Associates, Claimant's Attorneys
Jerome Larkin (SAIF), Defense Attorney

WCB 89-00766
August 9, 1989
Order Denying Motion to Dismiss

Claimant has moved the Board for an order dismissing the SAIF Corporation's request for review on the ground that a copy of the request was not timely served on the opposing party to the proceeding before the Referee. The motion is denied.

FINDINGS

The Referee's order issued May 3, 1989. On June 2, 1989, SAIF mailed a request for review of the order to the Board. The request, which was mailed by certified mail, included a certificate of personal service by mail upon claimant and his attorney. The certifiecate of personal service stated that a copy of the request had been mailed to claimant and his attorney on June 2, 1989.

ULTIMATE FINDINGS

SAIF's request for review was mailed to the Board within 30 days from the Referee's order. A copy of the request for review was mailed to claimant within 30 days of the Referee's order.

CONCLUSIONS

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

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

Here, the 30th day after the Referee's May 3, 1989 order was June 2, 1989. Since SAIF's request for Board review was mailed by certified mail on June 2, 1989, it is timely. See OAR 438-05-046(1)(b). Furthermore, SAIF provided a certificate of personal service attesting to the fact that a copy of its request had been mailed to claimant and his counsel on June 2, 1989. Inasmuch as service by mail is complete upon mailing, SAIF's notice to claimant is timely. See OAR 438-05-046(1)(b).

In support of his motion, claimant relies upon a recent decision by the Court of Appeals, Hein v. Columbia County, 96 Or App 576 (1989). In Hein, Columbia County's appeal from a Circuit Court judgment was filed on the 30th day. Included with the notice of appeal was counsel for the county's certificatoin that a

copy of the notice of apeal had been mailed to counsel for the adverse parties on the 30th day from the judgment. The court dismissed the appeal, concluding that notice of appeal had been served untimely on the adverse parties. In so doing, the court relied on ORS 19.028(1), and (2), which provide as follows:

> "(1) Filing a notice of appeal in the Court of Appeals or the Supreme Court may be accomplished by mail. The date of filing such notice shall be the date of mailing, provided it is mailed by registered or certified mail and the party filing the notice has proof from the post office of such mailing date. Proof of mailing shall be certified by the party filing the notice and filed thereafter with the court to which the appeal is taken. If the notice is received by the court on or before the date by which such notice is taken. If the notice is received by the court on or before the date by which such notice is required to be filed, the party filing the notice is not required to file proof of mailing.
> (2) Service of notice of appeal on a party * * * may be accomplished by mail subject to the same requirements as filing notice of appeal by mail as provided in subsection (1) of this section."

Hein is not controlling in this case. The statute that governs filing and service of appeals to the Court of Appeals is different from the Board's rules governing filing and service of requests for review in one critical respect. Although ORS 656.295 requires that notice of a request for review be mailed to all parties within the time provided for requesting review, it does not specify how notice shall be given. The Board has implemented the statute by adopting a rule that provides that timely service by mail may be established by he attorney's certificate, appended to the reequest for review filed with the Board, stating that a copy of the request has been deposited in the mail to listed individuals at listed addresses. OAR 438-05-046(2)(b).

In this respect, the Board's service rule differs from the statutory rule for service of appeals to the court which must either be received by other parties within the appeal period or must have been mailed by registered or certified mail within the appeal period and proof from the post office of such mailing retained by the mailing party. The court dismissed the appeal in Hein for failure to submit proof of timely mailing by registered or certified mail. Inasmuch as the requirement that mailing be accomplished by registered or certified mail is not contained in the Board's service rule, Hein is inapplicable. Counsel's certificate of mailing is sufficient under the Board's rule to establish timely notice.

Accordingly, the motion to dismiss is denied. Upon receipt of a transcript, copies will be provided to the parties and a briefing schedule implemented. Thereafter, this case will be docketed for review.

IT IS SO ORDERED.

MARVIN H. ALLEN, Claimant
James L. Francesconi, Claimant's Attorney
James E. Griffin, Assistant Attorney General

WCB TP-87028
August 10, 1989
Corrected Third Party Distribution Order

It has come to our attention that the Board's Third Party Distribution Order of July 27, 1989 contained several clerical errors. To correct these oversights, the July 27, 1989 order is withdrawn and replaced by the following order. The parties' rights of appeal shall run from the date of this order.

The SAIF Corporation, as paying agency, has petitioned the Board for an order declaring the validity of its liening the proceeds of a Third-party settlement and distributing those proceeds in accordance with ORS 656.593(3). Claimant contends that SAIF's lien is invalid because Michigan's no-fault motor vehicle insurance law precluded tort recovery from the third parties for the losses compensated by SAIF.

ISSUES

1. Whether claimant is estopped from contending that SAIF's lien is invalid.

2. Whether the fact that claimant's right of tort recovery was limited by Michigan law to certain categories of loss limits SAIF's right to share in the proceeds of claimant's settlement with the third parties.

FINDINGS OF FACT

Claimant sustained multiple severe injuries on June 6, 1984 when a truck in which he was a passenger collided head-on with another truck in the State of Michigan. Claimant and the driver of the vehicle in which he was riding, Hanlon M. Dodgion, were long haul truck drivers for American Hardwoods, an Oregon employer covered by SAIF. At the time of the accident, they were enroute from Timisking Station, Quebec to Portland, Oregon by way of Seattle, Washington. Both claimant and Dodgion were residents of Vancouver, Washington at the time of the accident. Claimant later moved to, and now resides in, Tualatin, Oregon. The other truck involved in the accident was owned by Twin Ports Grocery Company of Duluth, Minnesota. The driver of the truck, Glen K. Samberg, was a resident of the State of Minnesota. Both Dodgion and Samberg died in the accident.

Claimant filed a workers' compensation claim for his injuries which was accepted by SAIF. SAIF paid medical benefits, temporary disability compensation, vocational rehabilitation benefits and permanent total disability compensation. As of the date of its petition, SAIF had paid $137,741.05 in compensation and reasonably anticipated paying another $20,596.80 for a total of $158,337.85.

In a letter dated February 21, 1986, claimant's attorney informed SAIF that he had associated counsel in the State of Michigan and that a lawsuit would be filed within the next thirty days. In the last paragraph of the letter, claimant's attorney stated, "We will fully honor and protect your statutory lien on the June 6, 1984 claim."

On March 18, 1986, claimant commenced a diversity action against the estate of Glen K. Samberg and Twin Ports Grocery Company in the United States District Court for the Western District of

Michigan. Eight months later, claimant entered into a settlement agreement with Twin Ports Grocery Company and its insurer, Sentry Insurance Company (Sentry). A short time before entering into the agreement, claimant's attorneys informed SAIF that they considered its lien to be invalid and that it would not be allowed to share in the settlement proceeds. Under the settlement agreement, Sentry is to pay claimant, his estate or a designated beneficiary $1,500 per month for the rest of claimant's life or 15 years, whichever is longer. The last paragraph of the agreement provides, "The parties hereto agree that all of the consideration paid to Marvin Allen, Plaintiff, is consideration for non-economic loss. The parties agree that no portion of the settlement is consideration for economic loss."

At the time of the accident, Sentry had the written certification described in section 500.3163 of the Michigan Compiled Law Annotated (hereinafter MCLA) on file with the Michigan Department of Licensing.

CONCLUSIONS OF LAW

Claimant contends that the lien asserted by SAIF in the proceeds of his settlement with the third party is invalid because Michigan's no-fault motor vehicle insurance law precluded tort recovery from the third party for the losses compensated by SAIF. SAIF makes three arguments for the validity of its lien. First, it contends that its lien is at least partially valid even if the legal premise of claimant's argument is accepted because at least some of the losses compensated by SAIF were recoverable from the third party under Michigan law. Second, it contends that Oregon law grants it a lien in all of the proceeds of the settlement irrespective of the Michigan limitations on tort recovery. Third, it contends that claimant's attorney's representation that claimant would honor its lien estops claimant from contending that SAIF's lien is invalid. We address SAIF's arguments in reverse order.

I. Equitable Estoppel

To establish an equitable estoppel, SAIF has the burden of proving the following five elements: (1) there must be a false representation; (2) it must be made with knowledge of the facts; (3) the other party must have been ignorant of the truth; (4) the false representations must have been made with the intention that it should be acted upon by the other party; and (5) the other party must have been induced to act or rely upon it to his injury, detriment or prejudice. Donahoe v. Eugene Planing Mill, 252 Or 543, 545 (1969); Seguin v. Maloney-Chambers Lumber Co., 198 Or 272, 287 (1953); American Bank v. Port Orford Co., 140 Or 138, 144 (1932).

SAIF has proven only the first of the above elements. Claimant's attorney represented at one point that claimant would honor SAIF's lien. Later, this representation was withdrawn. The initial representation, therefore, was false. There is no evidence, however, that claimant or his attorney was aware at the time of the original representation that SAIF's lien might be invalid due to the limitation of claimant's tort recovery under Michigan law, that SAIF was ignorant of the possibility, that the representation was intended to induce any action or inaction on SAIF's part or that the representation actually induced SAIF to act or refrain from acting in a way which caused it any harm. We conclude, therefore, that SAIF failed to prove the elements of an equitable estoppel and that claimant may challenge the validity and extent of SAIF's lien on the merits.

II. The Validity and Extent of SAIF's Lien

As will be discussed more fully later, Oregon law generally grants a workers' compensation carrier a lien in damages or settlement proceeds recovered by a claimant from a third party for a compensable injury. Michigan law generally limits a person's right of tort recovery in motor vehicle accident cases to economic losses in excess of statutory maxima and non-economic losses such as pain and suffering. Michigan law also generally limits the right of a workers' compensation carrier to share in damage or settlement proceeds recovered in a third-party action to excess economic loss.

In view of the differences between Oregon and Michigan law and the arguments of the parties in this case, the Board must make the following three determinations to decide the issues of the validity and extent of SAIF's lien. First, it must determine the nature and extent of claimant's cause of action against the third parties. Claimant's argument is potentially valid only to the extent that Michigan law actually precluded recovery from the third parties for the losses compensated by SAIF. Second, the Board must determine whether Oregon or Michigan law controls SAIF's right to share in the proceeds of the settlement of claimant's cause of action. The parties assume in their major arguments that Michigan law controls. Third, the Board must determine the nature and extent of SAIF's rights under applicable law.

A. Claimant's Cause of Action Against the Third Parties

Claimant sustained his injuries in a motor vehicle collision in the State of Michigan. Under familiar choice of law principles, claimant's rights and the third parties' liabilities are determined by Michigan law. See Restatement (Second) of Conflict of Laws §§ 145, 146, 158 (1971). Under Michigan law, tort liability arising from the ownership, maintenance, or use of motor vehicles within the state generally had been abolished by the date of claimant's accident. MCLA §§ 500.3135(2), 500.3179 (1983). In place of tort liability, Michigan had instituted a no-fault system of "personal protection benefits." MCLA § 500.3135.

For purposes of the present case, personal protection benefits consist of "allowable expenses: and "work loss." MCLA § 500.3107. "Allowable expenses" are "all reasonable charges incurred for reasonably necessary products, services and accommodations for an injured person's care, recovery or rehabilitation," including those for "rehabilitative occupational training following the injury." MCLA §§ 500.3107(a), 500.3157. "Work loss" means:

> "loss of income from work an injured person would have performed during the first 3 years after the date of the accident if he had not been injured and expenses not exceeding $20.00 per day, reasonably incurred in obtaining ordinary and necessary services in view of those that, if he had not been injured, an injured person would have performed during the first 3 years after the date of the accident, not for income but for the benefit of himself or of his dependent." MCLA § 500.3107(b).

Further limitations on work loss at the time of

claimant's accident were that loss of income benefits were reduced by 15 percent due to their nontaxable status and the "[t]he benefits payable for work loss sustained in a single 30-day period and the income earned by an injured person for work during the same period together shall not exceed [$2,252.00], which maximum shall apply pro rata to any lesser period of work loss." MCLA § 3107(b) (1983 & Supp. 1988).

Although tort liability generally had been abolished in Michigan by the time of claimant's injury, full liability was retained in certain situations. See MCLA §§ 500.3101, 500,3135(2), 500.3163. One such situation is when an injury is caused by a nonresident of Michigan who is not covered by an insurer with a written certification of personal protection insurance coverage on file with the state. See MCLA § 500.3163. Michigan law also retains tort liability for several categories of loss under certain circumstances, two of which are applicable in the present case.

The first category is "[d]amages for allowable expenses [and] work loss . . . in excess of the daily, monthly, and 3-year limitations contained in [MCLA § 500.3107]." MCLA § 3135(2)(c). Although there are no "daily, monthly, [or] 3-year limitations" for allowable expenses, the Michigan courts have ruled that tort recovery for such expenses is limited to those not subject to personal protection insurance coverage. Swantek v. Automobile Club of Michigan Insurance Group, 118 Mich App 807, 809, 325, N.W.2d 588, 590 (1982); see Workman v. Detroit Automobile Inter-Insurance Exchange, 404 Mich 477, 511, 274 N.W.2d 373, 387 (1979).

The second category of loss which is applicable in this case is "[d]amages for noneconomic loss" in cases of injuries resulting in "death, serious impairment of body [sic] function, or permanent serious disfigurement." MCLA § 500.3135(1) & (2)(b). Claimant's injuries clearly resulted in "serious impairment of body function" within the meaning of MCLA § 500.3135(1). See DiFranco v. Pickard, 427 Mich 32, 67-70. 398 N.W.2d 896, 914-15 (1986). Claimant, therefore, could sue the third parties for noneconomic loss. "Noneconomic loss" is not defined in Michigan's no-fault chapter, but has been identified in the case law with damages for "pain and suffering." McKendrick v. Petrucci, 71 Mich App 200, 207-08, 247 N.W.2d 349, 352 (1976). It does not include loss of earning capacity; such loss is considered a nonactionable economic loss under Michigan's no-fault law. Quellette v. Kenealy, 424 Mich 83, 87-88, 378 N.W.2d 470, 472 (1985).

The third-party defendants in the present case, Glen K. Samberg and Twin Ports Grocery Company, were residents of Minnesota, not Michigan, but were insured by a company with a written certification on file with Michigan Department of Licensing. Under these circumstances, the third-party defendants had the "rights and immunities" provided by Michigan's no-fault law, MCLA 500.3163(3), and claimant's right of recovery against them was limited under MCLA § 500.3135 to noneconomic loss and allowable expenses and work loss in excess of the limitations contained in MCLA § 500.3107. Claimant could not sue the third parties for the medical or vocational expenses paid by SAIF or for temporary disability compensation payments within Michigan's statutory maxima. Whether claimant could sue for any of the payments for permanent total disability depends upon whether they

are classified as loss of income or loss of earning capacity. We need not decide that question at this point. Suffice it to say that claimant could not recover from the third party most, if not all, of the losses compensated by SAIF.

B. Whether Oregon or Michigan Law Controls SAIF's Right to Share in the Third-Party Settlement Proceeds

The parties assume in their major arguments that SAIF's right to share in the proceeds of claimant's settlement with the third party is a question of Michigan law. Claimant relies heavily upon the case of Great American Insurance Co. v. Queen, 410 Mich 73, 300 N.W.2d 895 (1980). There the Michigan Supreme Court ruled that a Michigan workers' compensation carrier's right to share in the proceeds of the settlement of a Michigan claimant's tort cause of action was limited to those categories of loss common to the workers' compensation claim and the claimant's cause of action. Id. at 96-97, 300 N.W.2d at 900-01. Claimant makes no argument based on Oregon law. SAIF's primary response to claimant's argument is that its lien is at least partially valid under the rule of Queen. It offers only a brief alternative argument that Oregon law should control and that its lien is valid under that law.

We concluded earlier that claimant's right of tort recovery against the third parties and the third parties' liabilities to claimant were determined by Michigan law. The basis of that conclusion was that the State of Michigan, with respect to those issues, had the most significant relationship to the parties and the subject matter of their dispute. See Restatement (Second) of Conflict of Laws § 145. The same conclusion does not follow on the issue of SAIF's right to share in the proceeds of claimant's third-party settlement. That issue concerns the relationship of an Oregon worker, and Oregon workers' compensation carrier and, indirectly at least, an Oregon employer. The State of Michigan has no substantial interest in whether SAIF is able to recover all, some or none of its compensation payments from claimant's settlement proceeds. The financial, social and legal impacts of that determination are centered in Oregon. Under these circumstances, Oregon has the most significant relationship to the parties and the subject matter of their dispute and its law should control. See Restatement (Second) of Conflict of Laws §§ 6, 145(2). The law of Michigan, like the law of any other foreign jurisdiction, is advisory only.

C. The Validity and Extent of SAIF's Lien Under Oregon Law

Under ORS 656.578 and 656.580(1), a worker who sustains a "compensable injury" due to the negligence or wrong of a third person not exempt from liability under ORS 656.018 or 656.154 is entitled to workers' compensation benefits and may also seek a civil remedy against the third person. In such situations, ORS 656.580(2) provides that "[t]he paying agency has a lien against the cause of action as provided by ORS 656.591 or 656.593, which lien shall be preferred to all claims except the cost of recovering such damages."

ORS 656.591 governs situations in which the claimant elects not to proceed against the third party and the claimant's "cause of action" is assigned to the paying agency. Although not

directly applicable in the present case, subsection (2) of that section employs the phrase "[a]ny sum recovered" in describing the fund to be divided between the paying agency and the claimant.

ORS 656.593 governs situations in which the claimant does proceed against the third party and recovers damages or settlement proceeds. Subsection (1) provides that the "proceeds of any damages recovered from [the] . . . third person shall be subject to a lien of the paying agency for its share of the proceeds as set forth in this section." The remainder of the subsection sets out the distribution scheme. Under that scheme, costs and attorney fees are deducted from the gross recovery, the worker is guaranteed at least one third of the remainder and the paying agency is granted "the balance of the recovery, but only to the extent that it is compensated for its expenditures for compensation . . . and for the present value of its reasonably to be expected future expenditures for compensation." Any excess of recovery goes to the worker.

Subsection (3) of ORS 656.593 concerns settlements. It authorizes the claimant to settle any third party case "with the approval of the paying agency." It then incorporates by reference the distribution scheme set out in subsection (1) except that it "authorize[s]" the paying agency "to accept such a share of the [settlement] proceeds as may be just and proper." In cases where a dispute has arisen concerning the proper distribution of settlement proceeds, the Board, as a general rule, has followed the distribution scheme prescribed for damage cases in ORS 656.593(1). See Marvin Thornton, 34 Van Natta 999 (1984). But see Robert T. Gerlach, 36 Van Natta 293 (1984).

In considering possible limitations on a paying agency's right to share in third-party recovery, we note initially that the paying agency's lien does not arise under the law of subrogation; it is purely a creature of statute. Newell v. Taylor, 212 Or 522, 530-33 (1958). The nature and extent of the lien created by the third-party provisions, therefore, must be sought not in the law of subrogation, but in the wording and intent of the provisions themselves.

On first reading, the third-party provisions appear to permit a paying agency to satisfy its lien out of any recovery achieved by the claimant. The references to "[a]ny sum recovered," in ORS 656.591(2), "[t]he proceeds of any damages" in ORS 656.593(1) and the "proceeds" of settlement in ORS 656.593(3) suggest that the paying agency's lien is coextensive with the claimant's total recovery irrespective of the nature of the recovery. Several other expressions, however, may suggest a different interpretation. Those expressions are "compensable injury" in ORS 656.578, "but only to the extent that [the paying agency] is compensated for its expenditures for compensation" in ORS 656.593(1)(c) and "just and proper" in ORS 656.593(3).

The phrase "compensable injury" in ORS 656.578 may be read two ways depending upon which of the two words is emphasized. If the word "compensable" is emphasized, the phrase may read to mean "the compensable aspects of the injury." If the word "injury" is emphasized, the phrase may be read to mean "the personal injury for which compensation was claimed." The first reading is preferable from the claimant's perspective because it would restrict the meaning of "cause of action" in ORS 656.580(2)

and thereby would limit the paying agency's lien to those aspects of the cause of action which are compensable under the Workers' Compensation Law. The second reading is preferable from the paying agency's perspective because it would allow the paying agency to satisfy its lien out of any recovery achieved by the claimant for the personal injury which gave rise to the workers' compensation claim. The same kind of ambiguity may be seen in the wording of ORS 656.593(1)(c) depending upon whether the word "compensation" or the word "expenditures" is emphasized. In addition, even assuming that these first two expressions do not represent legal limitations on the paying agency's lien, the phrase "just and proper" in ORS 656.593(3) may suggest equitable limitations.

In view of the ambiguities inherent in the above expressions, we turn for guidance to the legislative history of the third-party provisions. Although lengthy and complex, this history reveals a great deal about the purposes of the third-party provisions in general and the meaning of the ambiguous expressions noted above in particular.

The legislative history of the third-party provisions begins in 1913 with the original Workers' Compensation Act. Or Law 1913, ch 112. Section 12 of the Act imposed a duty upon a worker or the beneficiaries of workers who sustained a "personal injury by accident" due to the negligence or wrong of a nonexempt third party to elect whether to receive workers' compensation benefits or to pursue a remedy against the third party. If the worker or beneficiary elected to receive workers' compensation benefits, the section provided that the workers' or beneficiary's cause of action would be "assigned to the State for the benefit of the accident fund" (the precursor of the State Accident Insurance Fund). If the worker or beneficiary elected instead to pursue the third-party action, the section provided that "the accident fund [would] contribute only the deficiency, if any, between the amount of the recovery against such third person actually collected and the compensation proved or estimated by [the] act for such case."

The obvious purpose of the original third-party recovery section was to reduce the cost of the worker's compensations system as much as possible. In assigned cases, the section allowed the state to pursue the claimant's entire personal injury cause of action "for the benefit of the accident fund" and, potentially at least, to recover more than it had actually paid out in worker's compensation benefits. See Newell v. Taylor, supra, 212 Or at 528-29, 31. In cases in which the claimant elected to pursue the third-party action, the section limited the payment of workers' compensation benefits to the amount which the total third-party recovery fell short compared with what claimant would have received had he initially elected to assign his cause of action to the state. The section made no attempt to exclude from state recovery or consideration economic loss in excess of the limited payments permitted by the Act, or noncompensable, noneconomic losses such as pain and suffering or loss of consortium. The section also effectively placed the burden of paying any attorney fees and costs incurred in third-party actions on the claimant.

In 1925, the section was amended to limit the state's recovery in assigned cases to the total amount of its compensation and medical services payments plus the costs it incurred in

pursuing the third-party action. Or Laws 1925, ch 133 § 1. Recovery in excess of these expenditures was to be paid to the claimant. Id. The substance of this amendment is found today in ORS 656.591(2). Another amendment in 1933 allowed deduction of attorney fees and costs from the total third-party recovery in nonassigned cases before computation of the "deficiency, if any" which had to be made up out of the Industrial Accident Fund. Or Law 1933, ch 314 § 2. The net effect of this amendment was to shift the burden of paying attorney fees and costs in nonassigned cases from the claimant to the Industrial Accident Fund.

There are no committee reports or other historical materials which reveal the purpose of either of the above amendments. One obvious effect of both amendments, however, would be to maximize recovery in third-party actions. The 1925 amendment encouraged full cooperation by claimants in assigned third-party actions by guaranteeing them any excess recovery. The 1933 amendment encouraged full pursuit of nonassigned third-party actions by relieving claimants of the burden of paying attorney fees and costs our of their own pockets. By thus encouraging full recovery in third-party actions, the amendments enhanced the original purpose of the third-party section, namely, to reduce the cost of the workers' compensation system as much as possible. The amendments, of course, were also of some benefit to claimants; [Guaging from the primary effect of the amendments], however, this concern appears to have been secondary.

In 1937, substance of the lien provision which now appears in ORS 656.580(2) was added to the third-party recovery section. See Or Laws 1937, ch 356 § 1. The amendment provided that the worker or beneficiaries in nonassigned cases would

> "be paid the benefits provided by [the Workers' Compensation Act] in the same manner and to the same extent as if no right of action existed against the . . . third party, until the amount of benefits that the workman or beneficiaries are entitled to under this act can be determined and until damages are recovered from such . . . third party."

The amendment then created a lien in favor of the State Industrial Accident Commission (SIAC), the state agency charged with processing claims before the 1965 revision of the Workers' Compensation Law, in the amount of its current expenditures for compensation and medical services. No consideration was given to future compensation expenditures because the provision terminated the claimant's right to workers' compensation benefits once third-party recovery was achieved and distributed.

Again, there are no committee reports or other historical materials regarding the purpose of the 1937 amendment. Apparently, however, it was prompted by practical problems associated with the strict election of remedies procedure mandated by the original third-party section. Under that procedure, if the claimant elected to pursue the third-party action, he would not receive any compensation or recovery for his injury until the conclusion of the action. See Wimer v. Miller, 235 Or 25, 36 (1963); Manke v. Nehalem Logging Co., 211 Or 211, 223-24 (1957). If the claimant elected instead to receive full workers' compensation benefits, his cause of action was automatically and

irrevocably assigned to SIAC. See King v. Union Oil Co., 144 Or 655, 667 (1933); Williams v. Dale, 139 Or 105, 111-12 (1932); McDonough v. National Hospital Association, 134 Or 451, 458 (1930). The amendment allowed the claimant to receive workers' compensation benefits while pursuing the third-party action and at the same time protected SIAC's interest in the cause of action for the total dollar amount of its compensation and medical services payments.

In 1953, the basic distribution scheme now found in ORS 656.593(1) was added to the section. Or Laws 1953, ch 428, § 1. The amendment allotted to the claimant 25 percent of the third-party recovery in nonassigned cases after the deduction of attorney fees and costs. The balance of the recovery was allotted to SIAC "to the extent of [its] lien." Historical materials associated with the amendment are scant, but do include a measure analysis which indicates that the purpose of the amendment was to guarantee claimants an arbitrary but substantial share of third-party recovery as an incentive to pursue third-party actions. The amendment also effectively shifted the burden of paying attorney fees and costs back to the claimant by providing for their deduction from the gross recovery. The amendment did not expressly deal with the situation in which the recovery remaining after the deduction of attorney fees, costs and the claimant's statutory share exceeded the amount of SIAC's lien. This was corrected during the next legislative session through the addition of a provision which allotted any excess recovery to the claimant or the claimant's beneficiaries. Or Laws 1955, ch 656, § 1.

The provision governing the distribution of the proceeds of third-party settlements was added in 1955. The provision authorized claimants to settle third-party actions with the approval of SIAC and in such cases authorized SIAC to "accept such a share of the proceeds as in its discretion may be just and proper." Or Laws 1955, ch 656, § 1. Before the 1955 amendment, SIAC had no discretion to compromise the amount of its lien in order to facilitate a settlement between a claimant and a third party. The purpose of the amendment was to give SIAC that discretion. See Minutes, House Committee on Labor and Industries 1 (April 12, 1955).

The distribution scheme in nonassigned cases was amended in several important respects in 1959. The amendment provided that the claimant's entitlement to workers' compensation benefits in nonassigned cases would continue after the conclusion of the third-party action, increased the claimant's statutory share of third-party recovery after deduction of attorney fees and costs to 40 percent and provided that SIAC would retain the balance of the recovery irrespective of the amount of its lien. Or Laws 1959, ch 644, § 1. The new distribution scheme gave SIAC a windfall in those cases in which the balance it retained exceeded the amount of its lien. This windfall was thought necessary, however, to offset the cost of continuing workers' compensation benefits after the conclusion of the third-party action. See Minutes, Senate Committee on Judiciary 3-4 (April 16, 1959); see also Minutes, House Committee on Judiciary 2 (April 28, 1959).

The third-party provisions were amended again in 1965 as part of the comprehensive revision of the Workers' Compensation Law. Or Laws 1965, ch 285. One amendment substituted the phrase

"compensable injury" for the phrase "accidental injury" in what is now ORS 656.578. id., § 44. This change was occasioned by the chapter. See id. § 4. There is no indication in the legislative history that this change was intended to have any substantive significance. See Minutes, House Committee on Labor and Management 4 (January 25, 1965).

The 1965 amendments also revised the distribution scheme in nonassigned cases. Or Law 1965, ch 285, § 49. The amendment dealt with the problem of the cost of continuing workers' compensation benefits after the conclusion of the third-party action by permitting the paying agency to increase its lien by the present value of reasonably anticipated future compensation payments other than those for potential aggravation or own motion claims. In response to this change, the claimant's statutory share of the recovery was returned to 25 percent after deduction of attorney fees and costs, the paying agency was granted the balance of the recovery, "but only to the extent that it is compensated for its expenditures for compensation" and any excess recovery was allotted to the claimant. The only legislative history on these changes is a measure analysis which indicates that the purpose of the amendment was to eliminate the windfall to the applying agency in cases where the paying agency had paid very little in compensation and the claimant's recovery was relatively large.

The latest relevant amendment to the distribution scheme in nonassigned cases occurred in 1981. Or Laws 1981, ch 54 § 1. The bill originally introduced at that time would have increased the claimant's statutory share after deduction of attorney fees and costs to 75 percent. Senator Powell, the major sponsor of the bill, explained before the Senate Labor Committee that the bill was prompted by the impression that the claimant's recovery in third-party cases after the deduction of attorney fees and costs was often quite small and that this was not fair to the claimant. See Minutes, Senate Committee on Labor 1 (May 7, 1981). A number of business and workers' compensation insurance representatives spoke in opposition to the bill. They indicated that increasing the claimant's guaranteed share to 75 percent would decrease the workers' compensation carrier's incentive to investigate potential avenues of third-party recovery, would often result in double recovery to the claimant and would increase the cost of the workers' compensation system. See id. at 2-6. The committee ultimately reached a compromise between the 25 percent share guaranteed by the current law and the 75 percent share proposed by the original bill by amending the bill to provide for the current 33-1/3 percent guaranteed share. See id., at 6; Minutes, Senate Committee on Labor 1-2 (May 26, 1981).

In light of the above history it is apparent that the major purpose of the third-party provisions has been and continues to be to reduce the cost of the workers' compensation system as much as possible through third-party recovery. See Schlect v. SAIF, 60 Or App 449, 456 (1982); James H. Roberts, 34 Van Natta 1602, 1604 (1982). This purpose has been tempered over the years by practical and even equitable considerations to allow the claimant a share of the recovery. But the Legislature has never attempted to limit or define the paying agency's right to share in third-party recovery through reference to complicated technical

conceptions concerning the nature of the damages for which the third party is liable. We have no authority to create such a limitation. See United States v. Lorenzetti, 467 US 167, 176-79, 104 S Ct 2284, 2290-91, 81 L Ed 2d 134, 143-45 (1984) (employing similar reasoning to reject an identical argument under the third-party provisions of the Federal Employees' Compensation Act (FECA)).

We note parenthetically at this point that the Michigan Supreme Court's decision in Great American Insurance Co. v. Queen, supra, was based upon its conclusion that the primary purpose of the third-party provisions of its workers' compensation Act (in view of certain provisions of its no-fault Act) was to prevent double recovery by the claimant. See 410 Mich at 93-97, 300 N.W.2d at 888-901. Were the prevention of double recovery the primary purpose of Oregon's third-party provisions, we would be inclined to follow Queen. As already pointed out, however, that is not the purpose of our third-party provisions. Their primary purpose is to reduce the cost of the workers' compensation system as much as possible. Adopting the rule of Queen in this case would defeat that purpose.

Based upon the purpose of Oregon's third-party provisions and the legislative history reviewed above, therefore, we conclude that the phrase "compensable injury" in ORS 656.578 does not restrict the meaning of the phrase "cause of action" in ORS 656.580(2) for purposes of the present case and thus does not limit SAIF's right to satisfy its lien out of the proceeds of claimant's settlement. A good argument can be made that the expression does restrict the paying agency's lien to recovery for personal injury and thus does not allow the paying agency to share in recovery for property losses sustained in the industrial accident such as damage to the claimant's vehicle or clothing. See ORS 656.005(7)(a); cf. United States v. Lorenzetti, supra, 467 US at 174 n.3, 104 S Ct at 2289 n.3, 81 L Ed 2d at 142 n.3 (reaching this conclusion under the third-party provisions of the FECA). As far as the record reflects, however, claimant did not sustain any property losses in the present case and this potential limitation does not apply.

We reach a similar conclusion regarding the expression "but only to the extent that [the paying agency] is compensated for its expenditures for compensation" in ORS 656.593(1)(c). As is clear from the legislative history, this language was added in 1965 to limit the paying agency's share of third-party recovery to the total dollar amount of its lien. Under the 1959 version of the provision, the paying agency's share of the recovery could exceed that amount. The 1965 amendment, therefore, was not intended to restrict the paying agency's share of third-party recovery based upon the nature of the claimant's loss.

As for the phrase "just and proper" in ORS 656.593(3), its purpose is to authorize the paying agency to accept less than its full share of the third-party recovery in order to facilitate settlements. cf. Roger Reipe, 37 Van Natta 3 (1985); Robert T. Gerlach, supra, 36 Van Natta at 295-96. It does not require the third-party to accept less than the total dollar amount of its lien based upon the kinds of damages recoverable from the third party. Limitations on the kinds of damages recoverable from third parties is not unique to settlements. There is no reason, therefore, that the Legislature would treat settlements

differently in that respect. See Boldman v. Mt. Hood Chemical Corp., 288 Or 121, 132 (1980); Marvin Thornton, supra, 34 Van Natta at 1002.

Based upon the foregoing discussion, we conclude that SAIF's lien attached to and may be satisfied out of all of the proceeds of claimant's third-party settlement. We further conclude that a distribution of the entire settlement proceeds in accordance with ORS 656.593(1) would be "just and proper." See ORS 656.593(3); Robert L. Cavil, 39 Van Natta 721 (1987). Accordingly, claimant is directed to distribute the proceeds of the third party settlement in accordance with ORS 656.593(1).

IT IS SO ORDERED.

Board Member Crider, specially concurring:

I specially concur. Former Chairman Johnson, along with Member Ferris, authored the Board's July 27, 1989 Third Party Distribution Order. I neither signed that order nor submitted a dissenting opinion for the reason that I concurred with the result but disagreed with portions of the Board's reasoning. Inasmuch as Mr. Johnson is no longer on the Board, the Board consists of two members. Therefore, although I continue to disagree with portions of the text, I have proceeded to sign this order only to correct the clerical errors contained in the July 27, 1989 order.

DONNA E. ASCHBACHER, Claimant
Doblie & Associates, Claimant's Attorneys
Scheminske & Lyons, Defense Attorneys

WCB 88-07257
August 10, 1989
Order Denying Reconsideration

The insurer has requested that we abate and reconsider our July 13, 1989 Order on Review that set aside its denial of claimant's occupational disease claim for a low back condition. In addition, claimant has requested reconsideration of that portion of our prior order that declined to award an insurer-paid fee for her counsel's efforts on review in overturning the insurer's denial. Claimant encloses a statement of services concerning her counsel's efforts on review.

Former Chairman Johnson, along with Member Crider, signed the Board's majority opinion in the July 13, 1989 Order on Review. Board Member Ferris dissented. Inasmuch as Mr. Johnson is no longer on the Board, the Board consists of two members. The remaining members cannot reach agreement concerning the Motions for Reconsideration.

Accordingly, the parties' Motions for Reconsideration are denied by an evenly divided Board. The parties' rights of appeal shall continue to run from the date of our July 13, 1989 order.

IT IS SO ORDERED.

Board Member Crider, specially concurring:

I write solely in response to the insurer's request that I recuse myself from further consideration of this matter.

I cannot agree with the insurer's after-the-fact contentions. In this regard, the insurer does not argue that I

possess either an improper personal or pecuniary bias in this matter. See Boughan v. Board of Engineering Examiners, 46 Or App 287 (1980). Nor does the insurer contend that I have had improper personal contacts with the parties to this matter. Id. at 293. Further, the insurer does not suggest any personal knowledge on my part as to the particular factual context of this dispute. Id. All of the above might, under appropriate circumstances, warrant recusal in a given case.

Rather, the insurer notes that, prior to my appointment to the Board, I served as Administrator to the Senate Committee on Labor during the 1987 session of the Legislative Assembly. The insurer further notes that my employment duties with the Senate Committee on Labor occasioned statements of opinion on my part regarding the new occupational disease law, the interpretation of which is at issue in this case. The insurer does not contend that this participation in deliberations on the occupational disease law itself required that I not participate in the Board's consideration of this case. Instead, the insurer makes an argument that is based solely on the result reached by the Board majority: That is, the insurer argues that my statements as Administrator are at variance with the majority's position here, and that, because of my participation in the majority opinion, this variance results in the "appearance of impropriety." The insurer concludes that I am bound to recuse myself in order to avoid this appearance of impropriety.

I disagree with the insurer's conclusion. First, as the insurer apparently recognizes, there would be nothing untoward about my participation in this case had I reached the contrary result. If I had cited my own statements during the Senate Committee's deliberations in support of the view that major contributing cause remains the test for all occupational diseases, all would be well. That practice, of course, of citing one's own comments during legislative deliberations is not uncommon in the courts of this state. See e.g., State v. McClure, 298 Or 336, 347 n. 7 (1984) (Justice Jones, writing for the Court, cites to his prior testimony as a member of the Oregon Evidence Revision Commission before the Senate Justice Committee in support of the Court's interpretation of OEC 609); State v. Caruso, 289 Or 315 (1980) (Justice Tanzer, writing for the Court, cites to his prior legislative testimony as Solicitor General in support of the Court's interpretation of ORS 138.060(1)).

The insurer's objection arises because I did not rely on my comments before the Committee in resolving this case. Assuming, however, that the rules of ethics applicable to judges are applicable in this context, those rules do not have anything at all to do with the result a judge reaches in deliberations on a matter before him. Rather, they preclude a judge from any participation at all when such participation creates an appearance of impropriety. In such cases the judge must recuse himself. Principles of ethics do not operate to require a judge, otherwise not required to recuse himself, to choose between adhering to views stated on a question of law in another forum or withdrawing from participation in a new matter.

If recusal principles did operate in the fashion advocated by the insurer, they would have the effect of allowing a judge to participate in deliberations until such time as he determined that further study of a question would require him to

change his previously articulated view. At that point, he would either be required to sign an order at variance with his best understanding of the law or to withdraw from consideration of a case in midstream. Such a practice would not only have nothing to do with the rules of ethics, it would also interfere with a judge's ability to apply the law to the best of his ability and would interfere with the evolution of the law. Cf., State v. Isom, 306 Or 587, 597 (1988).

Second, rules aside, as a matter of fact, neither my participation in this case nor my participation coupled with the Board majority's decision, creates even an appearance of impropriety. The insurer contends that my opinions as Administrator are "completely contrary" to the majority's opinion in this case; and that it is this change of opinion which results in the appearance of impropriety. The insurer cites no personal bias or prejudice or personal knowledge of disputed evidentiary facts motivating my "changed" opinion. See Canon 3 of the Oregon Code of Judicial Conduct. In addition, the "opinions" cited by the insurer consist of a single statement made in response to a question from a Committee member. I prefaced my answer by encouraging the Committee to solicit additional responses to the question asked; thereby I made it abundantly clear that I had not previously considered the question. As is conceded by the insurer, it was not until the question was placed directly before me in the form of this case that I had occasion to completely research and consider the issue. Under these circumstances, I fail to see how my conduct could create even the appearance of impropriety.

Third, Oregon law does not support the proposition that officials exercising quasi-judicial powers, as do Workers' Compensation Board members, must recuse themselves from matters where not to do so would create the appearance of impropriety. 1000 Friends of Oregon v. Wasco Co. Court, 304 Or 76, 84 (1987). In fact, as noted by the Court in 1000 Friends v. Wasco Co. Court, supra, the government ethics law appears to disfavor disqualification on the basis of appearances alone. See also, ORS 244.130(2) (court shall not void agency decision solely due to failure of official to disclose conflict of interest). The Oregon courts have recognized that the imposition of such a strict standard on quasi-judicial agency officers can result in unacceptably heavy costs to innocent litigants, as well as to the agency involved. Id. at 85.

Here, the cost of recusal to the parties and the agency is patent. If I had recused myself during the course of the Board's initial consideration of this matter, as logically follows from the insurer's after-the-fact recusal request, then only two members would have been available to participate in the decision-making process. Our operating statutes require the affirmative vote of two members in order to issue a decision. ORS 656.718. Former Chairman Johnson voted to set aside the insurer's denial. Member Ferris voted to uphold that denial. In the absence of my vote, the necessary Board majority would have been lacking and the administrative adjudication would have gone unmade. The law does not support such a drastic step in order to avoid the appearance of impropriety. See Eastgate Theatre v. Bd. of County Comm'rs, 37 Or App 745 (1978) (quasi-judicial officials should not abstain due to concern that motiviation might be suspect where refusal to vote results in absence of necessary

majority to act).

For these reasons, I would conclude that the insurer's recusal request is without merit.

LOUISE BETTS COURY, Claimant
LENA M. SPALITTLE, dba,
MR. & MRS. HAIR DESIGN & BEAUTY Products, Emp.
Carney, Buckley, et al., Claimant's Attorneys
Richard C. Pearce, Attorney
SAIF Corp Legal, Defense Attorney

WCB 87-05458 & 87-05459
August 10, 1989
Order Denying Reconsideration

The noncomplying employer requests supplemental reconsideration of our June 29, 1989 Order on Review that affirmed a Referee's order which: (1) found that claimant suffered a compensable injury; and (2) declined to set aside the SAIF Corporation's acceptance of claimant's injury claim, issued on behalf of the noncomplying employer. On July 27, 1989, we issued an Order on Reconsideration affirming and supplementing our prior order.

On July 27, 1989, the same day we withdrew our June 29, 1989 Order on Review and issued our Order on Reconsideration, the employer filed its petition for judicial review of our June 29, 1989 order with the Court of Appeals. See ORS 656.298(3). Thus, jurisdiction to consider this matter vested with the Court of Appeals upon the filing of the employer's appeal. See Pedro G. Alcala, 39 Van Natta 1161 (1987). Consequently, we do not now have jurisdiction to addres the employer's Supplemental Request for Reconsideration.

We have previously held that it is possible to withdraw an order after the filing of a petition for judicial review. Dan W. Hedrick, 38 Van Natta 208, 209 (1986). However, we exercise this authority rarely. Ronald D. Chaffee, 39 Van Natta 1135 (1987).

Under these circumstances, we decline to withdraw our June 29, 1989 Order on Review. 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). Assuming for the sake of argument that we had withdrawn our order for reconsideration, we would adhere to the reasoning expressed in our July 27, 1989 Order on Reconsideration.

IT IS SO ORDERED.

ROGER L. VOHS, Claimant
Merrill Schneider, Claimant's Attorney
Roberts, et al., Defense Attorneys

WCB 86-14035
August 10, 1989
Order on Review

Reviewed by Board Members Crider and Ferris.

Claimant requests review of those portions of Referee Mulder's order that: (1) declined to find that his low back injury claim had been prematurely closed by a Determination Order; (2) declined to grant either permanent total disability or an additional award of unscheduled permanent disability, beyond a prior total award of 20 percent (64 degrees) awarded by a Determination Order and Opinion and Order. In addition, claimant argues that inasmuch as the Referee set aside the insurer's surgery denial, he erred in proceeding to rate the extent of claimant's unscheduled permanent disability. Claimant, therefore, requests that the Board remand this case to the Referee for a

post-surgical rating of the extent of claimant's unscheduled permanent disability. Although the insurer did not formally cross-request review, it argues in its brief that the Referee erred in setting aside its surgery denial. On review, the issues are premature claim closure, compensability of the proposed low back surgery, remand, and extent of unscheduled permanent disability -- including permanent total disability.

The Board affirms the order of the Referee.

FINDINGS OF FACT

The Board adopts the findings of the Referee and makes the following additional findings.

Claimant's low back condition deteriorated after the issuance of the October 16, 1986, Determination Order. After Dr. Berkeley reexamined claimant on November 13, 1986, it was reasonable to expect further material improvement in claimant's condition from medical treatment or the passage of time. At the time of the March, 1988, hearing, claimant's condition was not medically stationary.

Claimant is 46 years of age. He is educated through the 11th grade. At the time of his 1978 injury, he was employed as a carpenter. His prior work experience consisted of jobs as a pressman, apartment manager/maintenance repair person, and a plumber. He has essentially remained out of work, since the 1978 injury. On May 3, 1986, Dr. Berkeley restricted claimant from frequently lifting more than 10 pounds, as well as from prolonged sitting, walking, or standing. Given the above, we find that claimant has mild permanent physical impairment due to the 1978 injury.

CONCLUSIONS OF LAW

The Board adopts the Referee's Conclusions and Opinion, save for the issue of the extent of claimant's unscheduled permanent disability. Although we affirm the Referee's decision to not award additional unscheduled permanent disability for claimant's low back, beyond the 20 percent previously awarded, we do so pursuant to our own analysis.

Although the Referee declined to find that claimant's low back injury claim had been prematurely closed by the Determination Order of October 16, 1986, he did find that claimant was entitled to low back surgery as recommended by Dr. Berkeley, claimant's treating neurosurgeon. On November 13, 1986, Berkeley observed a change in claimant's condition and reported, inter alia:

> "This patient's condition has deteriorated in the last month and a half. Since October 16, 1986, his condition became worse in that he developed increasing pain in the low back and he says that both feet feel very weak and tingly and he describes it as 'if walking on someone else's feet.' There was no intercurrent injury and no provocation."

A myelogram performed on November 20, 1986, revealed canal and lateral recess stenosis at L4-5, as well as bilateral nerve root

compression. Accordingly, Berkeley requested authorizaton to perform corrective surgery. Although the insurer denied Berkeley's request, the Referee set aside its denial.

Under such circumstances, we conclude that claimant's low back condition changed after the issuance of the October 16, 1986, Determination Order. See Schuening v. J.R. Simplot and Company, 84 Or App 622 (1987). Inasmuch as we find nothing in the record to indicate that claimant's condition thereafter restabilized, we further conclude that his low back condition was not medically stationary at the time of the hearing. Accordingly, because claimant's aggravation rights expired prior to the October 16, 1986 Determination Order, the Referee should have rated the extent of claimant's unscheduled permanent disability as it existed on October 16, 1986; i.e., prior to the deterioration in his condition. Pauline L. Travis, 37 Van Natta 194 (1985).

Claimant seeks remand of this case so that the Referee can reevaluate the extent of his permanent disability after claimant undergoes surgery. We decline to grant claimant's motion. The Board may remand if it determines that the record has been improperly, incompletely or otherwise insufficiently developed. ORS 656.295(5). Here, the record was properly and completely developed. We need not remand to address the extent of disability issue. See Travis, 37 Van Natta at 196.

In rating the extent of unscheduled permanent disability for claimant's low back condition, we consider his physical impairment, his testimony -- insofar as it pertains to his condition up to October 16, 1986, -- and 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, 296 Or 505 (1984).

Claimant, 46, has an 11th grade education and no GED certificate. His work experience has been limited to heavy labor jobs primarily within the construction trade. At the time of his 1978 injury, he was working as a carpenter. He has essentially remained unemployed since that time and is physically unable to return to carpentry work. He cannot regularly lift in excess of 10 pounds. In addition, he must avoid prolonged sitting, walking, or standing. He suffers mild permanent physical impairment due to the 1978 injury.

Under such circumstances, we conclude that claimant's prior award of 20 percent unscheduled permanent disability adequately compensates him for his loss of earning capacity due to the 1978 injury. We, therefore, agree with the Referee's ultimate disposition, although for different reasons, of the extent of disability issue.

Claimant's attorney is entitled to an assessed fee for services on Board review in prevailing against the insurer's informal cross-request for review on the medical services issue. See Frances Gentry, 40 Van Natta 1697 (1988). However, inasmuch as claimant's attorney has not submitted a statement of services to date, we are unable to presently award an assessed fee. OAR 438-15-010(5).

ORDER

The Referee's order, dated June 15, 1988, is affirmed. The Board approves a client-paid fee, payable from the insurer to its attorney, not to exceed $1,171.50.

CARMEN M. CUDE, Claimant
Gleeson & Davis, Claimant's Attorneys
Nelson, et al., Defense Attorneys

WCB 88-18881
August 11, 1989
Interim Order of Dismissal

The insurer requested Board review of Referee Tenenbaum's order that: (1) increased claimant's scheduled permanent disability award for loss of use or function of her right forearm (wrist) from 5 percent (7.5 degrees), as awarded by a Determination Order, to 25 percent (37.5 degrees); and (2) increased claimant's scheduled permanent disability award for loss of use or function of her left forearm (wrist) from 5 percent (7.5 degrees), as awarded by a Determination Order, to 21 percent (31.5 degrees). The insurer has withdrawn its request for review. Consequently, its request for Board review is dismissed.

Inasmuch as claimant's cross-request for review of that portion of the Referee's order which affirmed a Director's order concerning a vocational services issue remains pending, we retain jurisdiction over this matter. Therefore, this dismissal order is interim and will be incorporated into our final, appealable order.

Because the briefing schedule has expired, this case will be docketed for review.

IT IS SO ORDERED.

ROSEMARY GOINS, Claimant
Robert E. Nelson, Claimant's Attorney
Kenney Roberts, Defense Attorney

WCB 88-16121 & 89-01512
August 11, 1989
Order Denying Motion to Dismiss

The self-insured employer moves for dismissal of claimant's request for review of a Referee's order on the ground that claimant did not request review. The motion is denied.

FINDINGS

Referee Bennett's order in WCB 88-16121 issued January 6, 1989. Pursuant to the order, the employer was assessed a penalty and attorney fee for unreasonable claims processing. The Referee also upheld the employer's denial of claimant's back injury claim.

On January 24, 1989, the Board received a handwritten letter from claimant. The letter, which was dated January 20, 1989, stated that "referring to my recent claim . . . I would like to have a decent hearing on this case." In the letter, claimant also asserted that "I am covered by Workers' Compensation & I expect to get my fair part of this."

The letter, which was neither mailed by registered nor certified mail, did not include an acknowledgment of service or a certificate of personal service by mail upon any party to the proceeding before the Referee. However, the employer's claims administrator received a copy of the letter on January 27, 1989. Thereafter, the copy was forwarded to the administrator's attorney.

Claimant's letter was initially processed as a hearing request under WCB Case No. 89-01512. On February 23, 1989, claimant, through her recently retained legal counsel, asserted that the letter was intended to be a request for Board review of the Referee's January 6, 1989 order and should be processed as such.

On March 30, 1989, the Referee in WCB Case No. 89-01512 submitted a memorandum to the Board, which discussed the procedural situation and the parties' respective positions. On April 10, 1989, the Board mailed a computer-generated letter to the parties acknowledging a request for review of the Referee's January 6, 1989 order. On April 26, 1989, the hearing request in WCB Case No. 89-01512 was dismissed. On May 18, 1989, the employer requested review of the dismissal order in WCB Case No. 89-01512.

ULTIMATE FINDINGS

Claimant requested Board review of the Referee's January 6, 1989 order within 30 days of its issuance. All parties received notice of the request within 30 days from the date of the Referee's order.

CONCLUSIONS

A Referee's order is final unless, within 30 days after the date on which a copy of the order is mailed to the parties, one of the parties requests Board review under ORS 656.295. ORS 656.289(3). Requests for Board review shall be mailed to the Board and copies of the request shall be mailed to all parties to the proceeding before the Referee. ORS 656.295(2). Compliance with ORS 656.295 requires that statutory notice of the request for review be mailed or actual notice be received within the statutory period. Argonaut Insurance Co. v. King, 63 Or App 847, 852 (1983). "Party" means a claimant for compensation, the employer of the injured worker at the time of injury and the insurer, if any, of such employer. ORS 656.005(19).

The request for review by the Board of a Referee's order need only state that the party requests a review of the order. ORS 656.295(1). While no "magic words" are required for compliance, the statute contemplates a modicum of information sufficient to clearly identify a document as a party's request for Board review of a Referee's order. Gerardo V. Soto, Jr., 35 Van Natta 1801, 1803 (1983). Where a party has not expressly requested Board review, but their intention to do so is both clear and unmistakable, we have concluded that we have jurisdiction pursuant to ORS 656.295. See Rochelle M. Gordon, 40 Van Natta 1808 (1988).

Here, claimant's January 20, 1989 letter does not expressly request Board review of the Referee's January 6, 1989 order. Yet, her statements that she desired "a decent hearing on this case", is "covered by Workers' Compensation" and "expect[s] to get [her] fair part of this" logically leads to that conclusion. Moreover, the timing of these comments, coming approximately two weeks after the Referee's order, lends further support for the conclusion that claimant was dissatisfied with the Referee's order and was determined to continue her pursuit of compensation concerning this case.

Considering the aforementioned circumstances, we conclude that claimant's letter was a request for Board review of the Referee's January 6, 1989 order. Inasmuch as the letter was received within 30 days of the Referee's order, it is timely. ORS 656.289(3).

We turn to the issue of whether the remaining parties received timely notice of claimant's request. We conclude that timely notice was provided.

On January 27, 1989, the employer's claims administrator

received a copy of claimant's January 20, 1989 letter. Thereafter, the administrator forwarded the letter to its legal counsel. For the reasons discussed above, we consider the letter to be a request for Board review of the Referee's January 6, 1989 letter. Consequently, the claims administrator received timely notice of the request. ORS 656.295(2).

Finally, the employer does not contend that it has been prejudiced by its failure to receive actual notice of the request for review. Absent such a finding, the claims administrator's timely notice of the request for review is adequate compliance with ORS 656.295(2) to vest jurisdiction in the Board. Nollen v. SAIF, 23 Or App 420, 423 (1975), rev den (1976); Rochelle M. Gordon, supra.

Accordingly, the motion to dismiss is denied. Inasmuch as the briefing schedule in these consolidated cases has been completed, these cases shall be docketed for review.

IT IS SO ORDERED.

OMA GORMAN, Claimant
SAIF Corp, Insurance Carrier

Own Motion 89-0400M
August 11, 1989
Own Motion Order

The SAIF Corporation has submitted to the Board claimant's claim for an alleged worsening of her March 11, 1982 industrial injury. Claimant's aggravation rights have expired. SAIF opposes reopening of claimant's claim on the basis that her allegedly worsened condition did not require surgery or hospitalization.

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

Following our review of this record, we do not find that claimant's allegedly worsened condition has required either surgery or hospitalization. At most, claimant received outpatient treatment by steroid injection during a two-hour stay at the Pain Management Clinic. That treatment does not rise to the level of "surgery" or "hospitalization" that is required for the Board to exercise its own motion authority under the current law. Therefore, claimant's request for own motion relief is denied.

IT IS SO ORDERED.

STEVEN L. JOHNSON, Claimant
Steven C. Yates, Claimant's Attorney
Nancy Marque (SAIF), Defense Attorney

WCB 87-12475
August 8, 1989
Order on Review

Reviewed by Board Members Crider and Ferris.

Claimant requests review of Referee Huffman's order that: (1) upheld the SAIF Corporation's partial denial of claimant's current low back condition; (2) found that claimant's cervical claim was not prematurely closed; (3) affirmed a Determination Order that did not award unscheduled permanent disability; (4) upheld SAIF's denial of claimant's aggravation

claim for his current neck condition; and (5) declined to assess penalties and attorney fees for unreasonable claims processing. The issues on review are premature claim closure, compensability, extent of permanent disability and penalties and attorney fees.

The Board affirms and adopts the order of the Referee, except that we disavow her comment on page 4 that "The propriety of closure must be evaluated in light of the information available at the time of closure." That is not the law. Rather, propriety of closure must be evaluated in light of claimant's condition at the time of closure and not of subsequent developments. Post-closure evidence may be considered insofar as it is relevant to whether claimant's condition at the time of closure was likely to improve with time or treatment. Scheuning v. J.R. Simplot & Co., 84 Or App 622 (1987).

It is claimant's burden to prove that the claim was closed prematurely. Austin v. SAIF, 48 Or App 7 (1980). There is no evidence in this record with regard to claimant's condition between December 1986, when he was released to work, and May 29, 1987 when the claim was closed. Although Dr. Hart, chiropractor, reported that claimant was not stationary in June, 1987, his report does not address claimant's condition on the date of closure. Moreover, it would appear, based on the opinions of Drs. Kuller and Kho, that the low back and neck conditions, which Dr. Hart believed were not stationary in June 1987 were not related to the compensable injury, but rather to a noncompensable scoliosis. For these reasons, claimant has failed to establish that he was not medically stationary at the time of closure.

ORDER

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

CAROL J. KNAPP, Claimant
Mike Stebbins, Claimant's Attorney
Daniel Spencer, Defense Attorney

WCB 86-12220
August 11, 1989
Order Denying Request

Reviewed by Board Members Crider and Ferris.

Claimant's counsel seeks an award of an assessed fee for services on review which culminated in our April 25, 1989 Order on Review. The request is denied for lack of jurisdiction.

FINDINGS

On April 25, 1989, we reversed a Referee's order that had upheld a denial of claimant's aggravation claim, declined to award temporary total disability benefits, and refused to assess penalties and attorney fees for alleged unreasonable claims processing. We further stated that since no statement of services had been received from claimant's counsel, no assessed fee could be awarded. Our April 25, 1989 order has neither been appealed, abated, stayed nor republished.

On August 3, 1989, the Board received a statement of services and cover letter from claimant's counsel. The statement and letter were dated May 1, 1989.

CONCLUSIONS

Pursuant to our April 25, 1989 order, claimant prevailed against an aggravation denial. Thus, claimant is entitled to a reasonable carrier paid attorney fee. ORS 656.386(1). Yet, we conclude that we lack jurisdiction to award such a fee.

A Board order becomes final unless, within 30 days of its issuance, it is appealed, abated, stayed or republished. ORS 656.295(8); International Paper Co. v. Wright, 80 Or App 444, 447 (1986). Here, none of the aforementioned circumstances occurred. Therefore, our April 25, 1989 order has become final by operation of law.

We have previously held that, when our prior order has addressed either the entitlement to or the amount of an attorney fee, our authority to consider a request for an attorney fee is contingent upon our retaining jurisdiction over our prior order. See Gabino R. Orozco, 41 Van Natta 599, 775 (1989); Jane E. Stanley, 40 Van Natta 831 (1988). Inasmuch as our April 25, 1989 order addressed the issue of claimant's counsel's entitlement to an assessed fee and since that order has become final by operation of law, we lack jurisdiction to consider claimant's request for an assessed fee.

In reaching this conclusion we note that claimant's request and statement of services are dated May 1, 1989, which is shortly after our April 25, 1989 order. As stated in Betty J. Eyler, 40 Van Natta 977 (1988), we make every effort to process requests which are received while we still retain jurisdiction. However, in this instance, the aforementioned request and statement were not received by the Board until August 3, 1989. Unfortunately, by that time, the 30-day period to further consider our April 25, 1989 passed without Board action.

Accordingly, claimant's request for an assessed fee is denied for lack of jurisdiction.

IT IS SO ORDERED.

HUIE D. KNIGHT, Claimant
Benton Flaxel, Claimant's Attorney
SAIF Corp Legal, Defense Attorney

WCB 82-05496
August 11, 1989
Order on Review

Reviewed by Board Members Ferris and Crider.

The SAIF Corporation requests review of Referee Johnson's order which granted claimant permanent total disability; whereas a Determination Order had awarded a total of 75 percent (240 degrees) unscheduled permanent disability, 15 percent (22.5 degrees) scheduled permanent disability for each of claimant's legs, and 10 percent (19.2 degrees) scheduled permanent disability for the left arm. The issues on review are permanent disability, including permanent total disability. We reverse the permanent total disability award and reinstate the Determination Order awards.

FINDINGS OF FACT

On July 28, 1980, claimant, while employed as a heavy equipment operator, was compensably injured when he was thrown

from the cab of a Terex S-12 scraper and was pushed or dragged by the machine for about 20 feet (Exhibit 17). Claimant suffered multiple injuries as a result of this industrial accident: a fracture of the left mandible plus bilateral mandibular rami fractures; a fracture of the left humerus; a fracture and dislocation of the left femur; a fracture of the pubic rami with separation of the pubic symphysis; loss of consciousness and probable concussion; a torn medial collateral ligament and anterior cruciate ligament in the right knee; and a laceration of the axillary nerve of the left deltoid muscle (Exhibits 2-16, 18-20, 24, 27, 28-31, 34-36). Claimant underwent several surgical procedures immediately following his industrial accident. He has not returned to work since his 1980 accident.

Claimant's claim was first closed by a June 15, 1982 Determination Order. He was awarded temporary total disability from July 28, 1980 through February 25, 1982, 50 percent unscheduled permanent partial disability for his left shoulder and left hip, and scheduled permanent partial disability for 25 percent loss of the left leg. (Exhibit 55).

Claimant's claim was reopened in October 1982 for a total left hip joint replacement (Exhibit 61 and 63). He dislocated his left hip twice in early 1983 and was hospitalized on each occasion (Exhibits 69, 70, 73, and 74). During the next several years he received conservative follow-up treatment from his treating physician, Dr. Whitney. He also received counseling for psychological/emotional symptoms resulting form his 1980 injury and its sequelae.

Claimant's claim was closed again by a Determination Order issued on March 20, 1986. He was awarded additional temporary disability from October 27, 1982 through February 24, 1986. The Determination Order also modified claimant's previous awards of permanent disability. He was granted a total unscheduled permanent partial disability award of 75 percent. In addition, he was granted total scheduled awards for 15 percent loss of the left leg, 5 percent loss of his right leg, and 10 percent loss of the left arm (Exhibits 138 and 144).

Claimant suffered an industrial injury to his low back in 1968 when he was working for another employer. As a result of this injury, he had a laminectomy and two-level spinal fusion. Claimant's 1980 work injury worsened his back condition. His present overall low back impairment is mildly moderate, which includes the contribution from his preexisting low back condition and the contribution form his 1980 work injury (Exhibit 120, pages 9-10 and Exhibit 127).

In 1976 claimant injured his groin area while working in the woods for another employer. This injury resulted in chronic groin pain and chronic severe thrombophlebitis of the lower left leg. Said injury produced substantial permanent impairment due to the groin pain, such that claimant was precluded from heavy work and also suffered limitations regarding sitting and standing. Claimant also suffered severe impairment regarding the right leg. The permanent disability resulting from his 1976 injury preexisted his July 1980 injury and has not increased since the 1980 injury (Exhibits i, j, 42a, 47a, and 132, page 4).

Claimant was 36 years old at the time of the December

1986 hearing. He graduated from high school in 1968. He subsequently attended Southwestern Oregon Community College for several years, where he obtained an Associate of Arts degree in forestry in 1974. His cumulative grade point average was 3.89 (Exhibit 157, page 4). Claimant has been employed as a heavy equipment operator, forest worker, forest technician, forest engineer technician, and timber sale layout aide. He has also done farm work, logging, mill work, ornamental iron work, and has worked as a gas station attendant. He has an intellectual capacity that is above average. His academic skill levels and learning abilities are sufficient for most vocational objectives (Exhibit 157, page 8).

Claimant has suffered severe physical impairment as a result of his 1980 injury: he is limited to sedentary type work on a less than full-time basis. Further, he needs to be able to control his environment with regard to sitting and standing. He has also suffered psychological/emotional impairment as a result of his 1980 injury. However, considering his injury-related impairment along with his preexisting impairment he is not totally incapacitated from work from a medical standpoint alone.

In addition to the substantial permanent impairment claimant has suffered regarding unscheduled areas as a result of his 1980 injury, he has suffered, as a result of said injury, a partial loss of use of the left leg, right leg (knee), and left arm.

Claimant has suffered no impairment to his oral maxillofacial and craniofacial areas as a result of his 1980 injury (Exhibit 136).

Claimant requires vocational training in order to be employable at a gainful and suitable occupation.

Claimant has received vocational rehabilitation services since his 1980 injury. In the fall of 1986 he was offered a vocational rehabilitation training program. The program was consistent with his physical capacities and mental abilities and successful completion of the program would probably have made him employable. Claimant unreasonably refused to undertake the offered training program.

OPINION AND CONCLUSIONS

Permanent total disability means the loss, including preexisting disability, of use or function of any scheduled or unscheduled portion of the body which permanently incapacitates the worker from regularly performing work at a gainful and suitable occupation. A suitable occupation is one which the worker has the ability and the training or experience to perform or an occupation which he is able to perform after rehabilitation. See ORS 656.206(1). Permanent total disability can be based upon total incapacity from a medical standpoint alone or less than total incapacity which together with such nonmedical conditions as age, training, aptitude, adaptability to nonphysical labor, mental capacity, emotional condition, and condition of the labor market prevent the worker from regularly performing work at a gainful and suitable occupation. See Wilson v. Weyerhaeuser, 30 Or App 403, 409 (1977). Claimant has the burden of proving

permanent total disability status and must establish that he has made reasonable efforts to obtain regular gainful employment. ORS 656.206(3).

The extent of claimant's permanent impairment will be addressed first. Dr. Baker, an orthopedic surgeon, evaluated claimant in January 1985. He subsequently reported that he did not believe that claimant was totally disabled. He opined that claimant was limited to, but capable of, sedentary type work (Exhibit 104, page 3). The Orthopaedic Consultants evaluated claimant in July 1985. They opined that claimant had permanent impairment with respect to the various body parts injured in 1980 that ranged from mild to moderately severe. Although they felt that claimant has suffered "considerable" impairment as a result of his injury, they did not opine that he was totally disabled from a purely medical standpoint (Exhibit 120, pages 9-10).

Dr. Whitney, claimant's treating physician, has expressed his opinion regarding claimant's permanent impairment on a number of occasions. His opinions have not been entirely consistent. Several times he has offered the conclusory opinion that claimant is permanently and totally disabled (Exhibits 89, 98 and 151). However, at other times he has indicated that he feels that claimant is not totally disabled from a medical standpoint alone. For example, he concurred with the evaluations of Dr. Baker and the Orthopaedic Consultants, who, as indicated earlier, did not opine that claimant was totally disabled medically (see Exhibits 105 and 127). Dr. Whitney's views regarding claimant's residual impairment were expressed in the greatest detail in his December 27, 1984 physical capacities assessment (Exhibit 102, page 9) and in his March 11, 1985 report (Exhibit 112). In the former, Dr. Whitney cited restrictions regarding lifting/carrying, bending, and other activities that amount to a limitation to sedentary work. Dr. Whitney also indicated that claimant needs to change positions frequently during the day: 30 minutes maximum at one time with respect to standing or walking, and 60 minutes maximum at one time with respect to sitting. He assessed claimant's total sitting capacity in one day as 3 hours and his total standing and walking capacities as 2 hours each. In his March 11, 1985 report Dr. Whitney advised that claimant needs to be able to control his own environment with regard to the amount of sitting, etc. He added that claimant may only be able to work for short periods of time and cannot work an 8 hour shift.

Claimant injured his low back and had a two-level fusion prior to his 1980 injury. The evidence does not establish specific activity restrictions regarding his low back prior to the 1980 injury, but given the existence of a two-level fusion we are not persuaded that claimant's low back was totally unimpaired. According to the Orthopaedic Consultants, with whom Dr. Whitney concurred, claimant has mildly moderate low back impairment, a portion of it due to the worsening effect of the 1980 injury and a portion due to his preexisting low back condition.

Claimant injured his groin area in 1976. The reports of Dr. Massey, claimant's treating physician regarding his 1976 injury, establish that claimant has a substantial degree of permanent impairment regarding his groin area and left leg, and to a lesser extent, his right leg, as a result of the 1976 injury (Exhibits i, j, 42a, 47a, and 132, page 4). Dr. Massey's reports

establish that said impairment preexisted claimant's 1980 injury and has not increased since the injury. In this regard, we note that Dr. Massey reported in April 1981 that claimant reached maximum improvement in June 1979. He further indicated that claimant's injuries (referring to the 1980 injury) since then had not impacted his preexisting groin/left leg conditions (Exhibit 42a). The residuals of claimant's 1976 injury do not add to his overall physical impairment. Rather, they simply form an independent basis for some of claimant's current overall impairment, especially regarding sitting/standing/walking.

Considering Dr. Whitney's reports as a whole and the reports of Dr. Baker, the Orthopaedic Consultants, and Dr. Massey, we find that claimant is not totally incapacitated from a physical standpoint alone.

The evidence establishes that claimant has experienced psychological/emotional symptoms since his 1980 injury that are compensably related to the injury and its sequelae. Two psychiatrists, Dr. Holland and Dr. Hughes, have opined that claimant has an injury-related psychological problem. However, at the time they saw him, in January and August 1985, they did not feel that he was medically stationary from a psychiatric standpoint, so they did not address the question of the extent, if any, of his permanent psychological impairment (Exhibit 103, page 16 and Exhibit 124, page 3). Mr. Bossardt, the clinical social worker who has been providing counseling to claimant since early 1984, has also opined that claimant's psychological/emotional problems are causally related to his 1980 injury. He opined in his September 24, 1985 report that claimant had become stationary as of September 17, 1985 (Exhibit 125, page 1). He further advised that claimant would need supportive counseling from time to time in the future to deal with the depression that might arise because of his pain and physical limitations. He concluded that he saw no reason from a psychiatric standpoint why claimant could not return to work (Exhibit 125, page 2). He reiterated this opinion in his October 29, 1985 report (Exhibit 129, page 2). In his July 10, 1986 report, Bossardt indicated that claimant has some degree of psychological/emotional impairment: his depression manifests itself in behavior such as irritability or decreased productivity. Mr. Bossardt stated that claimant's degree of impairment may vary from day to day or week to week. However, he did not retract his previously stated opinion that claimant is not barred, from a psychiatric standpoint, from returning to work (Exhibit 152, page 2).

We rely on the reports of Mr. Bossardt in determining the question of extent of psychological/emotional impairment. As the professional who has seen claimant on a frequent basis for his psychological/emotional problems, he is in an excellent position to assess the extent of claimant's residual problems. Based upon Mr. Bossardt's reports we find that although claimant does have some residual psychological/emotional impairment as a result of his 1980 injury and may need supportive counseling from time to time in the future, his psychological/emotional problems do not contribute to his overall impairment to the extent that he is totally prevented from returning to work.

Based upon the above discussed evidence and reasoning, we are not persuaded that claimant is permanently and totally disabled from a medical standpoint alone. The question is whether

he is permanently and totally disabled considering his very substantial impairment along with the pertinent nonmedical factors. These factors, such as age, education, mental capacity, and work experience, have been set forth in our findings. Considering claimant's impairment and these nonmedical factors, and the various vocational rehabilitation reports that are in the record, we are persuaded that claimant requires retraining in order to be employable at regular gainful work. A worker's potential employability after retraining cannot generally defeat a permanent total disability claim. See Gettman v. SAIF, 289 Or 609, 614 (1980). However, a permanent total disability claim is defeated where the claimant has unreasonably refused to undertake or complete an offered course of vocational rehabilitation. See Taylor v. SAIF, 67 Or App 193, 195-6(1984). Taylor is consistent with the statutory and case law requirement that a claimant make reasonable efforts to obtain regular gainful employment unless it would be futile for him to do so given his impairment alone or his impairment combined with the pertinent nonmedical factors. The question in this case is whether claimant has satisfied such a requirement.

Claimant received a substantial amount of vocational rehabilitation assistance in 1985 and 1986. In September 1986 a training program was developed and presented to him. The vocational objective was computer programmer. The plan provided for formal classroom training at Southwestern Oregon Community College (SWOCC) and correspondence classes through Portland State University. The training program was projected to run from late September 1986 to late August 1987 (Exhibit 156). Claimant decided to undertake the program (Exhibit 156, 157 and 158a, page 4). He advised his vocational counselor that he wanted to pursue self-employment in the horticulture business. Because the vocational rehabilitation rules do not allow for vocational assistance in connection with self-employment, claimant's vocational file was closed (Exhibit 158a, page 4-5).

At the hearing, Ms. Walker, claimant's vocational counselor, and Ms. Wicks, a vocational consultant who reviewed claimant's vocational training program at SAIF's request, both testified that the computer programmer training plan was viable for claimant. No contrary testimony was presented form any other vocational expert. Ms. Walker testified that Dr. Whitney was given a job analysis of a computer program position and he approved it with the single comment "education time may need to be lengthened due to tolerance in sitting" (Exhibit 157, pages 19-21 and Tr., page 123). Ms. Walker stated that after she received Dr. Whitney's approval of th job analysis she took claimant's sitting tolerances into account in developing the training plan (Tr., 123-124). She spoke to the personnel at SWOCC in the course of developing the training plan and was advised that everything possible would be done to accommodate claimant's needs to adjust his positions (Tr., page 118 and Exhibit 153, page 1). The PSU correspondence courses would have been done at claimant's home, where he would have been free to make his own necessary accommodations to his sitting tolerance. Claimant's ultimate employment was envisioned to be out of his home using equipment purchased by SAIF (Tr., pages 153-154). Ms. Walker testified that claimant was made aware that he would be able to work out of his home doing the computer work (Tr., page 129). Ms. Wicks testified that modifications would be made, such as adjustable tables/desks and chairs to accommodate claimant's need to change position (Tr.,

page 170). Although one computer programmer employer advised that two years of schooling would be required (Exhibit 157, pages 9 and 19), Ms. Walker testified that based upon her contacts with SWOCC and PSU claimant would not need two years of training (Tr., page 130, and se Exhibit 153, page 1). Ms. Walker reported that the labor market survey results regarding computer programming indicated reasonable job opportunities for trained job seekers (Exhibit 157, page 9). Ms. Wicks did her own labor market survey and testified that it showed potential for employment in the Coos Bay area in the field of computer programming (Tr., page 168). Both Ms. Walker and Ms. Wicks found several examples in the Coos Bay area of computer programmers working out their homes (Tr., page 154 and 171). Ms. Walker testified that she felt that the reason claimant did not want to pursue the computer programmer training plan was because he wanted to try to go into the horticulture business on a self-employment basis (Tr., pages 127 and 130-131, and see Exhibit 158, page 4 and 158a, page 4). Ms. Wicks testified that claimant told her that he wanted to be self-employed in horticulture (Tr., pages 165 and 169).

Claimant indicated in his testimony that his primary concern regarding the computer programmer training plan and subsequent employment and regarding regular employment in general is his lack of alertness and ability to concentrate because of his poor sleep patterns and pain. He testified that he can only concentrate on a work project 1-2 hours (Tr., pages 42-43 and page 181). However, he also testified that he thinks he could support himself in the horticulture business (tr., pages 103-105). He did not indicate why his alertness/concentration problems would not interfere with running his own horticulture business. We find persuasive Ms. Walker's opinion that claimant declined the computer programmer training plan because he preferred to pursue self-employment in the horticulture business. Evidence in the record from claimant himself supplies an explanation for this preference. Claimant has expressed the view more than once over the years that he does not like working indoors at a desk job. He has always preferred outdoor work (Exhibit 90, pages 3-4, and Tr., pages 12 and 56).

It is possible that claimant's concern about his ability to successfully participate in and complete a computer programmer training plan and thereafter obtain and hold employment might have proved accurate. However, claimant has not made a persuasive case as to why he could not have at least made a bonafide attempt at the offered training program. We find that his refusal to make such an attempt was not reasonable and we conclude that, pursuant to ORS 656.206(3) and Taylor he is not entitled to an award of permanent total disability.

The remaining question is claimant's entitlement to permanent partial disability, unscheduled and scheduled. Unscheduled permanent partial disability is based upon loss of earning capacity. The evaluation of loss of earning capacity considers claimant's permanent impairment resulting from his injury along with such factors as age, education, training and work experience. We have found that claimant has suffered a substantial degree of impairment in unscheduled areas as a result of his 1980 work injury. Combined with the pertinent nonmedical factors, we are persuaded that he has suffered a very large loss of earning capacity. But we also find that he already had some loss of earning capacity prior to his 1980 injury because of the

1976 groin injury. We conclude that claimant has been adequately compensated for his loss of earning capacity resulting from the 1980 injury by the 75 percent award granted in the March 20, 1986 Determination Order.

Scheduled permanent partial disability is based upon loss of use of the injured member resulting from he injury. Considering claimant's testimony and the medical evidence in the record, we find that claimant has a major loss of use of his left leg. But considering the substantial loss of use of the left leg that he already had prior to his 1980 injury, we conclude that the award of 15 percent scheduled permanent partial disability that he has already been granted adequately compensates him for his loss of use of the left leg as a result of the 1980 injury. Regarding the right leg, claimant injured his right knee in his 1980 injury and subsequently underwent surgery. He testified that his right leg gets along better than any other part of his body. He added that his right leg is relatively stable and does not give way on him (Tr., pages 34.35). The Orthopaedic Consultants assessed claimant's right knee impairment as a result of his 1980 injury as mild (Exhibit 120, page 10). Dr. Whitney concurred with their evaluation (Exhibit 127). We conclude that the 5 percent award for the right leg that claimant has already received adequately compensates him for the right leg/knee disability he has suffered as a result of his 1980 injury.

Claimant testified that he still gets a burning pain in his left arm that comes and goes depending upon his activity. He stated that lifting aggravates his pain. He also experiences numbness and tingling the left hand at the inside of the left elbow. He stated that he experiences weakness in his left arm and shoulder (Tr., pages 28-30). In reviewing his testimony concerning his left shoulder and arm it is not always clear whether the problems he is describing have their source in the arm or the shoulder (Tr., page 30). When the Orthopaedic Consultants saw claimant in July 1985, no complaints regarding the arm, as distinct from his shoulder, were noted (Exhibit 120, page 4). They noted excellent biceps and triceps muscle strength, though there was some left upper and lower arm atrophy relative to the right side (Exhibit 120, page 7). They rated claimant's impairment of the left shoulder and arm as moderately severe (Exhibit 120, page 10). It seems clear from the complaints they recorded and their findings that said impairment level was mostly with respect to the shoulder. As noted earlier, Dr. Whitney concurred with Orthopaedic Consultants' evaluation. Considering claimant's testimony together with the above discussed medical evidence, we find that most of claimant's residual problems regarding the left shoulder/arm area are with respect to the shoulder and we conclude that the 10 percent award previously granted properly compensates claimant for his residual injury-related problems regarding the arm itself.

ORDER

The Referee's order dated March 19, 1987 order is reversed. The March 20, 1986 Determination Order, is affirmed.

THOMAS LUND, Claimant
Richard D. Gatti, Claimant's Attorney
Raymond Smitke (SAIF), Defense Attorney

WCB TP-89005
August 11, 1989
Third Party Distribution Order

Reviewed by Board Members Crider and Ferris.

Claimant's counsel has petitioned the Board for the allowance of costs and an extraordinary attorney fee for services rendered in connection with a third party judgment. See ORS 656.593(1)(a). Specifically, counsel seeks approval of costs in the amount of $4,419.39, and an attorney fee equal to 40 percent of a purported $32,278.68 judgment, i.e., $12,911,47. The paying agency objects to both the amount of the costs and the extraordinary attorney fee request. We find that some of the costs sought to be reimbursed are not recoverable in this forum and that extraordinary circumstances do not exist to justify the requested attorney fee.

FINDINGS

Claimant suffered compensable injuries while working as a long-haul truck driver. Specifically, he was injured in a motor vehicle accident in September 1985 while travelling in Idaho. The driver of the other vehicle involved in the accident was killed. As a result of the collision, claimant suffered left shoulder, low back and right knee injuries. Claimant had previously experienced injuries to his left shoulder, neck, and right knee.

Claimant subsequently filed a third party action in the United States District Court in Idaho. It was necessary for claimant's counsel to associate with an Idaho attorney. The insurer for the third party defendant initially contested liability. Depositions were taken of three physicians, three employers, and several additional witnesses. Two weeks prior to trial, the third party insurer conceded liability.

Trial took place in the United States District Court in Pocatello, Idaho, from January 23 through January 26, 1989. The third party defendant argued at trial that claimant's post-accident complaints resulted from his pre-accident injuries. The defendant further contended that claimant's injuries attributable to the car accident were minimal.

At the conclusion of the trial, the jury returned a verdict in claimant's favor in the amount of $30,000. Claimant submitted a cost bill in the amount of $2,195.85. This cost bill consisted of the following items:

Filing fee	$ 120.00
Service of summons fees	88.45
Witness fees	167.60
Service of subpoena fees	113.80
Deposition costs	936.00
Expert witness	350.00
Printing and copying costs	420.00
Total	$2,195.85

Thereafter, a judgment was entered in the amount of $30,000, plus costs and interest of $2,278.68.

Claimant and his counsel have also incurred litigation

costs not otherwise recoverable from the third party. These expenses include: (1) $100 open file fee, which is in lieu of long distance charges, postage and office copying costs; (2) $1,346.03 for claimant's counsels' airfare and travel expenses; (3) $682.15 for claimant's travel expenses; and (4) $500 for claimant's lost wages prompted by his appearance at the trial.

Claimant's counsel estimates that approximately 200 hours were spent on the case by Oregon counsel and 80 hours by Idaho counsel. Counsel also estimates that four days were spent on depositions. In addition, counsel estimates that the medical record consisted of two to three thousand pages.

The paying agency has incurred actual claim costs of $21,851.06. Future medical expenditures of $3,000 are anticipated. These claim expenses are not contested.

FINDINGS OF ULTIMATE FACT

This third party case does not present extraordinary circumstances warranting an attorney fee in excess of one third of the gross recovery, less costs. The paying agency's lien for current costs is $21,851.06. During the litigation of the third party case, claimant's counsel expended reimbursable costs, not otherwise recoverable from the third party, in the amount of $1,446.03. During the litigation of the third party case, claimant incurred reimbursable expenses of $1,182.15.

CONCLUSIONS OF LAW

If a worker receives a compensable injury due to the negligence or wrong of a third person not in the same employ, the worker shall elect whether to recover damages from the third person. ORS 656.578. The proceeds of any damages recovered from the third person by the worker shall be subject to a lien of the paying agency for its share of the proceeds. ORS 656.593(1). The statutory formula for distribution of a third party recovery obtained by judgment is set forth in ORS 656.593(1).

To begin, costs and attorney fees incurred shall be initially disbursed. ORS 656.593(1)(a). The attorney fees in no event shall exceed the advisory schedule of fees established by the Board for third party actions. ORS 656.593(1)(a); Shipley v. SAIF, 79 Or App 149, 152-53 (1986).

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

Attorney Fee

The Board's advisory schedule concerning attorney fees in third party cases is set forth in OAR 438-15-095. The rule provides:

"Unless otherwise ordered by the Board after a

finding of extraordinary circumstances, an attorney fee not to exceed 33-1/3 percent of the gross recovery obtained by the plaintiff in an action maintained under the provisions of ORS 656.576 and 656.595 is authorized."

Claimant's counsel is requesting an extraordinary attorney fee of 40 percent of the third party recovery. In order to determine whether the circumstances here are extraordinary so as to warrant a fee in excess of 33-1/3 percent, we examine prior third party cases wherein extraordinary attorney fees have been awarded. See David S. Holcomb, 41 Van Natta 195 (1989).

In Leonard F. Kisor, 35 Van Natta 282 (1983), the Oregon counsel, a specialist in litigation involving the complex issue of asbestos exposure and mesothelioma, had associated with Washington counsel in order to take advantage of Washington's apparently more favorable products liability law. As an example of the complexity of the third party liability issue, the Oregon counsel referred to a similar case, which involved approximately 78,000 pages of documentary material. The paying agency did not object to an extraordinary fee; it only questioned whether it had authority to agree to a fee arrangement which would result in a fee exceeding 33-1/3 percent of the third party recovery. AFter reviewing the matter the Board allowed a fee equal to 40 percent of the proceeds from the third party recovery.

In John Galanopoulos, 35 Van Natta 548 (1983), claimant's counsel had proceeded with claimant's medical malpractice action after his prior counsel had recommended a $10,000 settlement. Legal and medical research, as well as investigation and trial preparation, occupied the vast majority of claimant's counsel's time for the three months preceeding the 5-day trial. The jury awarded claimant $139,000. Persuaded that these efforts expended by counsel in the course of preparing for and trying the malpractice action represented extraordinary services, the Board allowed an attorney fee equal to 40 percent of the third party judgment.

Finally, in John P. Christensen, 38 Van Natta 613 (1986), claimant's counsel had litigated the third party action over a 10-year period, including two presentations on pre-trial procedural issues before the Oregon Supreme Court. The case was finally tried some 9 years after the commencement of the action. That trial resulted in a mistrial. On the eve of the second trial, the third party action was settled for $87,500. The paying agency raised no objection to claimant's counsel's request for an attorney fee equal to 50 percent of the settlement proceeds. Given such circumstances, the Board allowed the extraordinary attorney fee request.

Here, claimant's counsel has spent many hours preparing for and participating in the federal court action. In addition, it appears that, in light of claimant's prior injuries, proof of the extent of claimant's damages was no simple matter. Moreover, counsel's representation of claimant was complicated by the fact of an out-of-state trial requiring association of a local attorney.

Yet, we are not persuaded that these circumstances warrant approval of an extraordinary fee. Neither the complexity of the issues nor the time required to prepare and try the case approach the levels found in Kisor, Galanopoulos and Christensen. In this regard, the third party defendant had conceded liability by the time of

trial. Further, the value of the interest involved was not insignificant and the results obtained were favorable to claimant; nevertheless, we are unable to find that they compare favorably with those present in the cases previously discussed. Moreover, we are not unmindful of the fact that claimant's share of the third party recovery will not be large even with a 33-1/3 percent attorney fee. Finally, the paying agency has objected to the requested fee. Consequently, we conclude that an extraordinary attorney fee is not justified.

Costs

Claimant's counsel requests the recovery of costs in the amount of $4,419.39. The paying agency suggests that recoverable costs should consist of only those costs claimant recovered in the trial court. We disagree.

ORS 656.593(1)(a) provides that costs and attorney fees incurred in the third party action shall be initially paid from the third party recovery. "Costs" means money expended by an attorney for things and services reasonably necessary to pursue a matter on behalf of a party, but do not include fees paid to any attorney. OAR 438-15-005(7).

Here, should the paying agency's contention to limit claimant's recovery of costs to court costs be followed, ORS 656.593(1)(a) is pointless. Court costs are recovered from the third party defendant pursuant to the judgment. If claimant's counsel's recovery of costs from the third party judgment is also limited to court costs, counsel is effectively permitted to be reimbursed from two sources for the same costs. i.e., the third party and claimant's recovery.

ORS 656.593(1)(b) provides that the worker shall receive at least one-third of the remaining balance after distribution of attorney fees and costs. Yet, if only court costs are recoverable, a worker would still remain contractually responsible for the balance of the litigation expenses pursuant to any standard attorney retainer agreement. Inasmuch as the source for reimbursement of these expenses would undoubtedly be claimant's recovery, the effect of the paying agency's approach would be to reduce claimant's statutorily guaranteed one-third share.

To further assist us in determining whether reimbursable costs are limited to court costs, we look to ORS 656.591. The aforementioned statute governs distribution of a third party judgment where the paying agent has prosecuted the action in the name of the worker. Upon securing the judgment, the statute provides for the recovery by the paying agency "of the expenses incurred in making such recovery." ORS 656.591(2). Consistent with this policy to recover litigation expenses and attorney fees "off the top" of the third party recovery, ORS 656.593(1)(a) states that incurred costs and attorney fees shall be paid.

Each of these sections ensure that attorney fees and litigation expenses are, in effect, shared by the paying agency and the worker. Thereafter, depending upon who prosecuted the cause of action, the statutes further guarantee a certain portion of the remaining balance of the recovery for the prosecutor of the action.

Our analysis of these statutes leads us to conclude that

claimant's reimbursable costs incurred during the litigation of a third party action are not limited to court costs. In this regard, we do not consider court costs to be the same as litigation expenses. For example, travel expenses are not recoverable as court costs. Yet, such expenses are certainly necessarily incurred as claimant and his counsel travel to an out-of-state trial and seek temporary lodging as the trial progresses.

To conclude that such expenses are not reimbursable from the third party recovery necessitates one of two alternatives. Either claimant must pay for such costs from his share of the recovery, thereby reducing his statutory share of the proceeds, or claimant's counsel must absorb the costs, thereby effectively reducing his statutorily granted attorney fee. We do not consider either alternative to be in keeping with the statutory scheme discussed above. Accordingly, we conclude that claimant is entitled to reimbursement from the third party recovery for previously unreimbursed costs which are reasonably and necessarily incurred during the litigation of the third party action.

In response to particular items recited in claimant's reimbursement petition, the agency contests claimant's request to recover travel expenses and airfare incurred by himself ($682.15) and his attorneys ($1,346.03), as well as his lost wages caused by his attendance at the trial ($500). We conclude that each of these expenses were reasonably and necessarily realized during the litigation of claimant's third party action. Inasmuch as none of these costs are recoverable from the third party, we hold that they are reimbursable from the third party proceeds pursuant to ORS 656.593(1)(a).

The paying agency also objects to claimant's counsel's $100 "open file fee." In response to the agency's objections, claimant's counsel asserts that the charge is in lieu of various and sundry long distance charges, postage fees, and xeroxing costs incurred during the pendency of claimant's third party action. Considering the distance between claimant's counsel's office and the site of the accident/trial, we consider such a fee reasonable. Furthermore, as with the travel expenses, such a cost is not recoverable from the third party. Therefore, because the fee was reasonably and necessarily incurred during the litigation of claimant's third party action, we conclude that the cost is likewise reimbursable. ORS 656.593(1)(a).

Finally, the paying agency objects to claimant's counsel's request for reimbursement for depositions ($1,018.80) and "Federal Express Deposition Copying and Miscellaneous Costs" ($233.56). We agree with the agency's objections.

Following the trial and verdict, claimant submitted a cost bill, which listed deposition costs totalling $936. Inasmuch as claimant sought and recovered reimbursement for $936 in deposition costs, we hold that he is not entitled to further recovery from the judgment absent explanation of the discrepancy between the two figures.

We follow similar reasoning regarding the "Federal Express Deposition Copying and Miscellaneous Costs" request. Claimant's counsel submits that such costs were incurred by claimant's Idaho counsel prior to and during the trial. Yet, as with the previously discussed deposition costs, copying and miscellaneous expenses were

requested from the third party and, in fact, claimant actually recovered $420 in printing and copying costs in accordance with his cost bill. Inasmuch as some such costs were recoverable in the third party action we conclude that claimant has failed to prove his entitlement to reimbursement for these costs because he has not persuasively explained the discrepancy between the cost bill, his prior recovery, and his current request.

Distribution of Proceeds

As previously discussed, we have concluded that claimant's counsel is to receive a 33-1/3 share of the recovery, rather that an extraordinary fee of 40 percent. We note parenthetically that we do not agree with claimant's counsel's contention that the fee should be based upon the sum of the $30,000 verdict plus the $2,278.68 costs and interest. To adopt counsel's approach would effectively allow him to recover one-third of his costs as attorney fees, then to separately recover his full costs again. Such a result would be unacceptable. To the extent ORS 656.593(1) and OAR 438-15-095 are unclear on this point, we interpret them to provide for reimbursement of costs first, then payment of an attorney fee based on the third party recovery.

We further conclude that claimant's counsel's costs recovery, in addition to costs and interests previously recovered through the third party judgment, is limited to $1,446.03. i.e., ($100 + $1,346.03). Finally, claimant is entitled to receive $1,182.15 ($682.15 and $500) for his travel expenses and lost wages. Therefore, the distribution schedule shall be as follows.

Claimant's counsel shall distribute $1,182.15 of the judgment proceeds to claimant. Claimant's counsel is then entitled to recover his previously unreimbursed costs of $1,446.03. Next, counsel is entitled to an attorney fee equal to 33-1/3 percent of the $30,000 third party judgment. i.e., $10,000. Thereafter, after deduction of these costs and attorney fees, claimant's attorney is directed to pay to claimant 33-1/3 percent of the remaining balance of the third party recovery. Finally, because it appears that the paying agency's lien for current uncontested compensation costs ($21,851.06) will exceed the remaining balance, claimant's counsel is directed to pay the paying agency the balance of the third party recovery.

IT IS SO ORDERED.

ERNEST E. McCOY, Claimant
Marshall Yager, Defense Attorney

WCB 88-14820
August 11, 1989
Order of Dismissal

Reviewed by Board Members Crider and Ferris.

Claimant has requested Board review of Referee McCullough's orders. We have reviewed the request to determine whether we have jurisdiction to consider the matter. Because we conclude that we lack jurisdiction, the request for review is dismissed.

FINDINGS

The Referee's Opinion and Order issued March 30, 1989. On April 24, 1989, claimant requested reconsideration of the Referee's order, submitting information not otherwise included in

the record. On April 25, 1989, the Referee issued an order suspending his prior order pending his review of claimant's motion for reconsideration. Thereafter, claimant submitted several additional documents not previously introduced at the hearing.

On June 12, 1989, the Referee issued an Order on Request for Reconsideration. Although some of the post-hearing submissions were admitted into evidence, the Referee concluded that their admission did not "warrant modification" of his prior order. Consequently, the Referee "fully reinstated" his March 30, 1989 order.

On July 14, 1989, claimant hand-delivered a request for review to the Board. The request indicated that a copy had been provided to the insurer's legal counsel.

ULTIMATE FINDINGS

Claimant's request for Board review was submitted more than 30 days after the Referee's order.

CONCLUSIONS

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

Here, because the Referee's March 30, 1989 order was timely withdrawn for reconsideration by the Referee's April 25, 1989 order, the 30-day statutory appeal period began with the issuance of the Referee's June 12, 1989 Order on Request for Reconsideration. The 30th day after the Referee's June 12, 1989 order was July 12, 1989. However, claimant's request for Board review was filed July 14, 1989. Under such 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.

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

Accordingly, the request for Board review is dismissed.

IT IS SO ORDERED.

ROBERT L. MONTGOMERY, Claimant
Robert Wollheim, Claimant's Attorney
Ridgway Foley, Defense Attorney

WCB 86-16320
August 11, 1989
Order on Review

Reviewed by Board Members Crider and Ferris.

The insurer, United Employers, requests review of Referee Shebley's order which awarded claimant 50 percent (160 degrees) unscheduled permanent disability for a low back condition, whereas a Determination Order had awarded no permanent disability. United Employers argues on review that whatever permanent disability claimant experiences preexisted his employment with its insured. Claimant responds that United Employers is precluded from asserting this argument by a prior Referee's order assigning responsibility for claimant's condition to United Employers. The issue is extent of permanent disability. We modify the Referee's award.

FINDINGS OF FACT

Claimant is 56 years old and a high school graduate. He worked 30 years as a grocery stocker and checker until September 1984. He worked for SAIF's insured for 20 years, until that store closed in February 1983. He sustained a compensable injury to his left shoulder in 1980 and injuries to his right ankle, right hip, left leg, and left arm in 1981. The claim arising out of the 1981 injury was closed in April 1981 with no award of permanent disability. He continued to work for SAIF's insured following these injuries, although he experienced gradually progressive symptoms which limited his ability to lift, bend, stoop and twist.

Approximately nine months after leaving SAIF's insured, claimant was employed by United Employers' insured. At the time of his employment, he continued to experience pain which limited his physical capabilities. Claimant worked for United Employers' insured for approximately three months until worsened symptoms forced him to quit that employment in September 1984. He has not worked since that time.

Both SAIF and United Employers denied responsibility for claimant's disability and need for treatment after he left work in September 1984. In May 1986, a prior Referee found United Employers responsible "for claimant's low back and right hip and leg condition." This order was affirmed by the Board on appeal.

The claim with United Employers was closed by Determination Order in November 1986. The Determination order awarded time loss only, with no award of permanent disability.

Claimant experiences multiple upper extremity symptoms which are unrelated to his compensable injury with United Employers.

Claimant suffered from permanent low back, hip and leg impairment when he commenced work for United Employers' insured. Claimant's low back, hip and leg conditions permanently worsened as a result of his employment with United Employers' insured. The permanent worsening due to his employment with United Employers' insured resulted in additional impairment in the mild range.

Claimant exaggerates the severity of his symptoms.

CONCLUSIONS OF LAW

United Employers argues that claimant has not proven that his condition permanently worsened during his employment with its insured. Claimant contends that the insurer's argument is an attempt to relitigate compensability of his claim. Claimant reasons that the prior Referee found that his work activities for United Employers' insured resulted in a worsening of his underlying condition. Consequently, claimant asserts, United Employers is now precluded from contending that his condition did not worsen during his employment with its insured.

Claimant mischaracterizes United Employers' argument. United Employers is not challenging the prior Referee's finding that claimant's condition worsened during his employment with its insured. Rather, United Employers argues that whatever worsening occurred did not result in increased permanent disability. The issue before the prior Referee was responsibility for claimant's back, hip and leg conditions. In order to assign responsibility to United Employers, it was necessary for the Referee to find that claimant's employment activities with United Employers' insured independently contributed to a worsening of claimant's underlying conditions. Hensel Phelps Construction v. Mirich, 81 Or App 290 (1986). The law does not require a finding of permanent worsening. Nor does a finding of permanent worsening necessarily result in entitlement to an increased award of permanent disability.

We find, however, that claimant's condition did in fact permanently worsen as a result of his work activities for United Employers' insured. Moreover, this worsening did result in entitlement to an award of permanent disability. In this regard, in September 1984, after several months work with United Employers' insured, claimant was unable to continue due to increased symptoms. These symptoms did not improve over the ensuing years preceding the July 1987 hearing. Moreover, our review of the medical record generally, and Dr. Long's reports in particular, persuade us that the increased symptoms experienced by claimant are permanent in nature.

Turning next to the question of disability, the criteria for rating of claimant's disability is the permanent loss of earning capacity "due to" the compensable injury. ORS 656.214(5). In this regard, we are not persuaded that claimant's permanent disability attributable to his work activities with United Employers' insured supports an award of 50 percent unscheduled permanent disability.

First, several examiners have noted claimant's tendency to exaggerate his symptoms. Dr. Nelson reported on November 15, 1984 that claimant overdramatizes his right leg pain. On February 5, 1987, Dr. Richard Rosenbaum noted functional features to claimant's condition. Drs. Frank, Long and Butler concurred with this report. Further, Dr. Long referred claimant to the Providence Rehabilitation Center for evaluation where he was found to have a strong tendency to magnify his symptomatic complaints. The rehabilitation report noted that claimant's pain behaviors disappeared when he was distracted. The report also noted that claimant's limp varied depending upon whether he was being observed. We conclude that claimant consciously exaggerates his symptoms.

In addition, claimant testified at length regarding his upper extremity complaints. However, claimant's compensable claim with United Employers relates to his low back, hip and legs. Moreover, there is no evidence that claimant's employment with United Employers' insured affected claimant's upper extremity conditions. Because claimant has not proven that his upper extremity conditions are "due to" his employment with United Employers' insured, claimant is entitled to no award of permanent disability for those conditions. ORS 656.214(5); Barrett v. D & H Drywall, 300 Or 325, as amplified 300 Or 553 (1985). Consequently, we do not consider claimant's upper extremity complaints in determining the extent of his compensable disability.

Similarly, United Employers asserts that claimant suffered from low back, hip and leg impairment when he commenced work for its insured. This assertion is supported by the record. Claimant testified to gradually increasing symptoms commencing with his injuries in 1980 and 1981. Claimant further testified that he was in pain when he went to work for United Employers' insured, and that this pain caused him to be less able to lift, bend, stoop and twist. Thus, while claimant did not receive an award of permanent disability for his 1980 and 1981 injuries, we are persuaded that claimant was suffering from some permanent low back, hip and leg impairment prior to commencing work with United Employers's insured.

Claimant bears the burden of proving the extent of his permanent disability. Hutcheson v. Weyerhaeuser Co., 288 Or 51 (1979). As a result of claimant's tendency to exaggerate his symptoms, the complicating factor of his noncompensable upper extremity conditions, and his preexisting impairment, we are unable to find that claimant sustained more than an additional mild permanent impairment "due to" his work activities for United Employers' insured.

To determine claimant's permanent loss of earning capacity, we consider his mild impairment and all of the relevant social and vocational factors set forth in former OAR 436-30-380 et seq. We apply these rules as guidelines, not as restrictive mechanical formulas. See Harwell v. Argonaut Insurance, 296 Or 505, 510 (1984). Claimant's age is a moderately negative factor. The fact that he is a high school graduate is essentially neutral. Although he is now limited to sedentary work, as discussed above, only a portion of that limitation is attributable to his employment with United Employers insured. We conclude that an award of 30 percent unscheduled permanent partial disability adequately and appropriately compensates claimant for his loss of earning capacity resulting from his employment with United Employers' insured.

ORDER

The Referee's order dated August 19, 1987 is modified. In lieu of the unscheduled permanent partial disability awarded by the Referee, claimant is awarded 30 percent (96 degrees) unscheduled permanent partial disability for his low back, hip and leg conditions. Claimant's attorney fees shall be adjusted accordingly. The Board approves a client-paid fee, payable from United Employers to its counsel, not to exceed $3,960.

RAYMOND E. TISDALE, Claimant
EBI Companies, Insurance Carrier

Own Motion 89-0417M
August 11, 1989
Own Motion Order

The insurer has submitted to the Board claimant's claim for an alleged worsening of his April 7, 1982, industrial injury. Claimant's aggravation rights have expired. The insurer apparently accepts responsibility for claimant's in-patient pain center treatment, but opposes reopening of his claim for temporary disability benefits on the ground that claimant has effectively withdrawn from the work force.

Under ORS 656.278(1)(a), we may exercise our "own motion" authority to reopen a claim 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.

Here, we do not reach the question of whether there has been a worsening of claimant's industrial injury requiring hospitalization, because we find that claimant has retired from the work force and, hence, is no longer a "worker" within the meaning of the Workers' Compensation Law. The record indicates that claimant has not worked since October, 1983, and is collecting retirement benefits. During his evaluation at the Oregon Pain Center in March, 1989, claimant "entertain[ed] the idea that return to work might be possible." However, despite medical evidence that he is capable of returning to light or sedentary work, claimant has not yet demonstrated a willingness to do so. Therefore, we find that claimant has effectively withdrawn from the work force. Accordingly, he is not entitled to temporary disability benfits. See Cutright v. Weyerhaeuser Co., 299 Or 290, 302 (1985); Karr v. SAIF, 79 Or App 250, rev den 301 Or 765 (1986). Claimant's request for own motion relief is denied.

IT IS SO ORDERED.

ELLEN L. CRAWFORD, Claimant
Michael B. Dye, Claimant's Attorney
Rick Dawson (SAIF), Defense Attorney

WCB 88-11895
August 14, 1989
Order Denying Reconsideration

The SAIF Corporation has requested that we abate and reconsider our July 13, 1989 Order on Review that upheld its denial of claimant's occupational disease claim for a stress-related mental disorder. SAIF contends in this regard that Board Member Crider should recuse herself from further consideration of this matter.

Former Chairman Johnson, along with Member Crider, signed the Board's majority opinion in the July 13, 1989 Order on Review. Board Member Ferris concurred in the majority's result but not with the majority's reasoning. Inasmuch as Mr. Johnson is no longer on the Board, the Board consists of two members. The remaining members cannot reach agreement concerning the Motion for Abatement and Reconsideration.

Accordingly, SAIF's Motion for Abatement and Reconsideration is denied by an evenly divided Board. The parties' rights of appeal shall continue to run from the date of our July 13, 1989 order.

Board Member Crider, specially concurring:

I write in response to the insurer's request that I recuse myself from further consideration of this matter.

I note, as a preliminary matter, that while the insurer's motion is styled a "Motion for Abatement, Request for Recusal and Reconsideration," the text of the motion seeks abatement and recusal only. The motion does not state any reason for seeking reconsideration of the Board's order. Ordinarily, under these circumstances, the motion to abate and reconsider would be denied. OAR 438-11-035(2).

I cannot agree with the insurer's after-the-fact contention that recusal is required in this case. In this regard, the insurer does not argue that I possess either an improper personal or pecuniary bias in this matter. See Boughan v. Board of Engineering Examiners, 46 Or App 287 (1980). Nor does the insurer contend that I have had improper personal contacts with the parties to this matter. Id. at 293. Further, the insurer does not suggest any personal knowledge on my part as to the particular factual context of this dispute. Id. All of the above might, under appropriate circumstances, warrant recusal in a given case.

Rather, the insurer notes that, prior to my appointment to the Board, I served as Administrator to the Senate Committee on Labor during the 1987 session of the Legislative Assembly. The insurer further notes that my employment duties with the Senate Committee on Labor occasioned statements of opinion on my part regarding the new occupational disease law, the interpretation of which is at issue in this case. The insurer contends that this participation in deliberations on the occupational disease law itself requires that I not participate in the Board's consideration of this case.

I disagree with the insurer's conclusion. Contrary to its assertion, there is nothing untoward about my participation in this case. It is not uncommon in the courts of this state for judicial officers to participate in cases involving the interpretation of laws concerning which they have presented testimony during legislative deliberations. See e.g., State v. McClure, 298 Or 336, 347 n. 7 (1984) (Justice Jones, writing for the Court, cites to his prior testimony as a member of the Oregon Evidence Revision Commission before the Senate Justice Committee in support of the Court's interpretation of OEC 609); State v. Caruso, 289 Or 315 (1980) (Justice Tanzer, writing for the Court, cites to his prior legislative testimony as Solicitor General in support of the Court's interpretation of ORS 138.060(1)).

Moreover, for practical reasons of administrative decision-making, the standard for recusal applied to quasi-judicial agency employees is less stringent than that imposed upon judges. As expressed by the court in Eastgate Theatre v. Bd. of County Comm'rs, 37 Or App 745, 751 (1978):

> "The most obvious difference between judicial and most quasi-judicial proceedings is that the consequences of disqualification are greater in the latter. In judicial proceedings as in

> football, when a judge steps out, he can be replaced from the bench and the adjudication can be made; before a[n administrative agency], as in rugby, however, there can be no substitution and the administrative adjudication may go unmade."

In this interest of allowing administrative agencies to function, the Eastgate court concluded that members of a quasi-judicial tribunal should not disqualify themselves from matters before them due to "official involvement in related governmental organizations and activities." Id., 37 Or App at 754. Accordingly, if purely judicial officials are not prohibited from participating in cases involving interpretation of laws concerning which they have presented legislative testimony, then the participation of quasi-judicial agency employees under similar circumstances is clearly proper.

For these reasons I would conclude that the insurer's recusal request is without merit.

KATHERINE A. RELPH, Claimant
Coons & Cole, Claimant's Attorneys
Roberts, et al., Defense Attorneys

WCB 84-03505
August 14, 1989
Order on Reconsideration

The insurer has requested reconsideration of those portions of our June 30, 1989, Order on Review, which: (1) affirmed the Referee's award of additional temporary disability compensation; and (2) assessed separate penalties and attorney fees for two allegedly unreasonably late denials. On July 18, 1989, the Board abated its order and allowed claimant to respond to the penalty and attorney fee matter.

In our June, 1989, order, we found that the insurer had unreasonably delayed issuing two denials: a compensability denial and an aggravtion denial. Consequently, we assessed a 25 percent penalty and an attorney fee for each unreasonable delay. The "amounts then due," however, overlapped. The compensation due at the time of the compensability denial, covered the period from January 3, 1985, through April 26, 1985. Overlapping with that "amounts then due," was the compensation due at the time of the later aggravation denial, which covered the period from January 3, 1985, through March 7, 1986.

A penalty and an associated attorney fee, see ORS 656.382(1), may be assessed "up to 25 percent of the amounts then due * * *." ORS 656.262(10). Here, the total amount of compensation due covers a period from January 3, 1985, through March 7, 1986. Because the insurer unreasonably delayed issuing its aggravation denial, we assessed a 25 percent penalty, and associated attorney fee, of the amounts then due for that total period. Consequently, there were no remaining "amounts then due" in which to assess an additional penalty and attorney fee. See D. Maintenance Company v. Mischke, 84 Or App 218 (1987); Sandra Brancham, 39 Van Natta 1267, 1275 (1988).

We, therefore, erred in assessing an additional penalty for the period from January 3, 1985, through April 26, 1985. In sum, on reconsideration, we do not assess a penalty for the insurer's unreasonably late compensability denial. Except as

modified herein, the Board adheres to and republishes its June 30, 1989 order, effective this date.

IT IS SO ORDERED.

MONTE L. WILBUR, Claimant
Scott Supperstein, Claimant's Attorney
Paul Roess, Defense Attorney

WCB 87-07746
August 14, 1989
Order on Review

Reviewed by Board Members Ferris and Crider.

Claimant requests review of those portions of Referee Podnar's order that: (1) rejected his contention that his claim had been prematurely closed; and (2) affirmed the Determination Order which awarded no permanent partial disability for his low back. We affirm.

ISSUES

1. Whether claimant's claim was prematurely closed.

2. Extent of disability for claimant's low back.

FINDINGS OF FACT

Claimant injured his low back on August 14, 1986 in the course of his employment as a truck driver when he pushed on a large roll of paper material to move it off of a truck. He sought treatment from Dr. Gabrielson, a chiropractor, in September 1986. Gabrielson diagnosed a lumbar strain and cervical and thoracic subluxations and began a course of frequent chiropractic manipulations. He also prescribed a home exercise program. The insurer denied claimant's claim in toto in November 1986 and issued a second denial relating specifically to claimant's cervical and thoracic conditions in January 1987. After a hearing on the insurer's denials in March 1987, the insurer was ordered to accept claimant's low back condition. The denial of the cervical and thoracic conditions, however, was upheld.

In November 1986, Gabrielson indicated that claimant's condition was improving slowly and that he anticipated another six months of treatment before claimant reached a medically stationary status.

Claimant was examined by Dr. Bussanich, a chiropractor, in late December 1986. At that time, claimant complained of intermittent minimal low back discomfort. Bussanich's examination revealed a short right leg, mild low back discomfort with thoracolumbar extension and right straight leg raising and some tenderness with palpation at L4 and L5-S1. His review of x-rays taken by Dr. Gabrielson in September 1986 revealed a scoliosis in the lumbar area which Bussanich attributed to the short right leg. He also commented that the x-rays showed a "loss of normal disc wedging" at L5-S1. He opined that claimant was "approaching a medically stationary status."

The day after Dr. Bussanich's examination, claimant was examined by Dr. Horniman, a general practitioner. Claimant complained of slight discomfort in his low back which he related to the examination the previous day. Dr. Horniman performed a

physical examination and reviewed the x-rays taken by Dr. Gabrielson. Dr. Horniman found no objective abnormalities and opined that claimant was medically stationary without permanent impairment.

On January 29, 1987, Dr. Gabrielson released claimant for modified work, effective December 8, 1986. No modified work was available with the employer and claimant remained off work. On March 26, 1987, Gabrielson reported that claimant's condition had improved considerably during the previous two months and that it appeared to be stabilizing. He anticipated declaring claimant medically stationary in another two or three months.

By letter of the same date as Dr. Gabrielson's report, the insurer informed Gabrielson that in view of the Referee's order upholding its denial of claimant's cervical and thoracic conditions, it would not pay for treatment to those areas. Gabrielson replied that he continued to believe that claimant's cervical and thoracic conditions were related to the August 1986 industrial accident and, in any event, that he charged a flat fee for his treatments regardless of whether he adjusted one area of the back or multiple areas. He then threatened, "Maybe a telephone call and a letter to the Insurance Commissioner will help you see clear to pay your bills."

In April 1987, claimant was examined by a panel of the Orthopaedic Consultants. Claimant complained of intermittent low back discomfort. The panel performed a physical examination, ordered new x-rays and reviewed past x-rays. These procedures revealed no objective signs of injury and the panel opined that claimant was medically stationary without permanent impairment.

In May 1987, Dr. Gabrielson reported that claimant experienced constant pain in his upper back and opined that he was not medically stationary. At one point in the report, Gabrielson erroneously stated, "It has been substantiated that [the low back] injury has caused a worsening of his upper back condition."

Claimant's claim was closed by Determination Order on May 26, 1987. The order noted the conflict in the medical evidence regarding claimant's medically stationary status, but found that claimant was medically stationary as of April 9, 1987, the date of the Orthopaedic Consultants examination. The order granted no award for permanent disability. Claimant requested a hearing.

In July 1987, claimant was examined by Dr. Whitton, a chiropractor, on referral from Dr. Gabrielson. Claimant complained of low back discomfort with physical exertion. Whitton's examination revealed a short right leg and mild discomfort with flexion and extension of the low back and with bilateral straight leg raising. Whitton also ordered new x-rays, which he interpreted to show assymetrical facets and facet sclerosing at L4-5 and L5-S1, an "increased sacral base angle" and a possible compression fracture of L5. Given this information, Whitton concluded that claimant's complaints were due to "internal derangements of the intervertebral discs by osseous structural disrelationships, causing irritation of the annular fibers and the posterior common ligaments." Based upon claimant's representations regarding continued improvement with Dr. Gabrielson's treatment, Whitton opined that claimant's

condition was "still acute at this time" and that claimant was not medically stationary. He recommended continued chiropractic treatment, home exercises and perhaps a "work hardening" program.

In a follow-up report elicited by the insurer, Whitton opined that the facet sclerosing that he had identified on x-ray was the primary cause of claimant's ongoing complaints. He indicated that facet sclerosing "usually takes years to occur," but that claimant's August 1986 industrial injury may have accelerated the process.

In November 1987, the insurer elicited a final report from Dr. Gabrielson. Gabrielson's report recites most of Dr. Whitton's conclusions, including the conclusion that claimant was not medically stationary. The report also contains a number of vitriolic comments and threats. Gabrielson continued to insist that claimant's cervical and thoracic complaints were compensable and commented, "Belaboring this point, which we have no problem in substanciating [sic], serves no purpose and is rediculous [sic], when considering that I'm doing you a favor and not charging for adjusting this area. So let's drop it while I'm still feeling generous."

The hearing was held in February 1988. At that time, claimant had been working as a truck driving instructor for about six weeks. He had not experienced significant low back complaints for several months.

FINDINGS OF ULTIMATE FACT

1. At the time of the May 1985 Determination Order, no material improvement in claimant's compensable low back condition was reasonably anticipated from medical treatment or the passage of time.

2. Claimant sustained no permanent low back impairment as a result of his August 1986 industrial injury.

CONCLUSIONS OF LAW

Premature Closure

ORS 656.268(1) provides in pertinent part: "Claims shall not be closed nor temporary disability compensation terminated if the worker's condition has not become medically stationary." ORS 656.005(17) provides: "'Medically stationary' means that no further material improvement would reasonably be expected from medical treatment, or the passage of time." Claimant contends that further material improvement in his low back condition was reasonably anticipated when the May 1987 Determination Order issued and thus that he was not medically stationary at that time. We disagree.

There are five opinions regarding claimant's medically stationary status. Dr. Bussanich opined that claimant was nearing medically stationary status in December 1986. Dr. Horniman thought that claimant had achieved medically stationary status at that time. The Orthopaedic Consultants opined that claimant was medically stationary in April 1987. These opinions were based upon thorough physical examinations and a review of x-ray evidence and are adequately explained.

Dr. Gabrielson himself opined that claimant was nearing medically stationary status in March 1987. His later opinions to the contrary are poorly explained and appear to be based upon his assessment of claimant's noncompensable cervical and thoracic conditions as well as the compensable low back condition. In any event, the attitude exhibited by Dr. Gabrielson in his reports causes us to question his objectivity.

As for the opinion of Dr. Whitton, his physical and x-ray examinations revealed little to support his conclusion that claimant's condition continued in an acute state. His treatment recommendations do not indicate that he reasonably expected further material improvement in claimant's condition. In view of these factors and the multiple contrary opinions, we do not find his opinion persuasive.

In accordance with the above discussion, we conclude that the evidence preponderates in favor of the conclusion that claimant was medically stationary by April 1987 at the latest and thus that his claim was not prematurely closed in May 1987.

Extent of Disability for Claimant's Low Back

The criterion for rating unscheduled permanent partial disability is the permanent loss of earning capacity due to the compensable injury. ORS 656.214(5). In determining loss of earning capacity, we consider medical and lay evidence of permanent impairment resulting from the compensable injury and all of the relevant social and vocational factors set forth in former OAR 436-30-380 et seq.

In the present case, the evidence does not support the conclusion that claimant has sustained any permanent impairment as a result of the industrial injury. The only medical professionals who rated the extent of claimant's permanent impairment rated it at zero. Claimant testified only to some minimal low back stiffness. On this record, we conclude that claimant has not proven entitlement to an award of permanent partial disability and affirm the Determination Order.

ORDER

The Referee's order dated February 29, 1988 is affirmed. A client-paid fee, payable from the insurer to its counsel, not to exceed $374, is approved.

JACKIE F. BARKLEY, Claimant
Malagon & Moore, Claimant's Attorneys
Brian L. Pocock, Defense Attorney

WCB 86-17096
August 15, 1989
Order on Review

Reviewed by Board Members Ferris and Crider.

The self-insured employer requests review of Referee Seymour's order which set aside its denial of claimant's occupational disease claim for bilateral carpal tunnel syndrome. On review, the sole issue is compensability. We affirm.

FINDINGS OF FACT

Claimant began working for the employer in February 1984. Prior to that time, claimant had worked as a waitress,

motel maid, bartender, and security guard. Claimant was initially assigned to the labor pool and did primarily clean up work as well as alternating on the green chain. While on the green chain claimant began experiencing hand and arm pain.

In May 1984, claimant was assigned to perform as a package saw operator. She was required to handle at least 1,000 pieces of lumber which had to be continually flipped and chalked. While performing this duty, claimant experienced pain, swelling tingling and numbness in her hands, arms and shoulders. She sought treatment from Dr. Woodworth, who diagnosed bilateral carpal tunnel syndrome. In May 1984, claimant filed a claim for bilateral carpal tunnel syndrome.

Dr. Woodworth prescribed wrist splints and claimant continued working. Approximately 18 months later, claimant assumed the position of hoist operator/loadout in the laminated beam plant. This position required her to wrap 100 individual beams in plastic each night. Claimant continued to experience pain, swelling, tinglng and numbness in her hands and arms.

In June 1986, claimant underwent nerve conduction studies, performed by Dr. Harris, neurologist. These studies were abnormal for the right and left median nerves. In October 1986, claimant was examined by Dr. Nathan, hand specialist. He diagnosed bilateral carpal tunnel disease and reported that this confirmed the clinical diagnosis of bilateral carpal tunnel syndrome. He felt that it would probably be necessary for claimant to undergo bilateral carpal tunnel releases. In November 1986, the employer denied claimant's bilateral carpal tunnel syndrome/disease.

FINDINGS OF ULTIMATE FACT

Claimant had not experienced carpal tunnel symptoms in her wrists and hands prior to her work with the employer.

Claimant's work exposure was the major contributing cause of her bilateral carpal tunnel syndrome.

CONCLUSIONS OF LAW

The Referee concluded that claimant's work activities were the major contributing cause of her bilateral carpal tunnel syndrome. We agree.

In order to prevail on an occupational disease claim, claimant must show that the work activity either caused the condition, or in the case of a preexisting condition, that the work activities caused a worsening of the underlying condition. Former ORS 656.802(1)(a); Wheeler v. Boise Cascade, 298 Or 452 (1985); Weller v. Union Carbide, 288 Or 27 (1979). In addition, a claimant must prove that the work activities were the major contributing cause of the condition, or its worsening. Roseburg Lumber Co. v. Killmer, 72 Or App 626 (1985).

Claimant's treating physician, Dr. Woodworth, noted that claimant had experienced no prior carpal tunnel syndrome signs or symptoms and opined that her work was the major contributing cause in the development of her carpal tunnel syndrome. Dr. Harris, who performed the original nerve conduction studies, also noted no

previous symptoms and felt it medically probable that claimant's work activities were the major contributing cause of her carpal tunnel syndrome. Dr. Teal, handsurgeon, opined that claimant's work activities would cause and aggravate carpal tunnel syndrome symptoms.

Conversely, Dr. Nathan opined that claimant had preexisting carpal tunnel disease and that claimant's work activities merely made the disease symptomatic, but did not worsen the carpal tunnel disease. He refers to this symptom complex as carpal tunnel syndrome.

Aside from Dr. Nathan's bare assertion, there is no evidence in the record that suggests claimant had a preexisting condition in her hands or wrists. We are not persuaded by Dr. Nathan's conclusory assertion that claimant had a preexisting condition as he had never observed claimant prior to the onset of her symptoms in May 1984. This conclusion is further supported by the fact that prior to May 1984, claimant had not experienced any symptoms relative to her hands or wrists. Accordingly, we find that claimant did not have a preexisting condition prior to the beginning of her employment in February 1984. See Devereaux v. North Pacific Ins. Co., 74 Or App 388 (1985).

Considering claimant's on-the-job repetitive use of her hands and wrists, the lack of similar off-the-job exposure, and our finding that claimant did not have a preexisting carpal tunnel disease prior to May 1984, as well as the opinions of Drs. Woodworth, Harris, and Teal, we conclude that claimant's work exposure was the major contributing cause of her bilateral wrist condition.

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

ORDER

The Referee's order dated August 14, 1987 is affirmed. A client-paid fee, not to exceed $400, is approved.

GERALD W. BARROW, Claimant
Malagon & Moore, Claimant's Attorneys
Meyers & Associates, Defense Attorneys

WCB 87-13062
August 15, 1989
Order on Review

Reviewed by Board Members Crider and Ferris.

Claimant requests review of that portion of Referee Blevins' order that rejected his contention that the insurer calculated his temporary total disability compensation at an incorrect rate. We affirm.

FINDINGS OF FACT

Claimant injured his low back on July 20, 1987 in the course of his employment as a shake bolt cutter. The employer

assigned its shake bolt cutters to work in a particular section of the woods and paid them on a production basis. The workers were allowed to set their own days and hours of work.

Claimant was paid $100 per cord, less 20 percent for saw rental, during the period from January 1, 1987 through June 25, 1987. From the latter date through the date of the injury, claimant worked with another worker and was paid $57 per cord, less 20 percent for saw rental. Between January 1, 1987 and the date of the injury, claimant earned a total of $1,964.90 and was paid an additional $491.23 for saw rental. Between February 1, 1987 and the date of his injury, he earned a total of $1,524.90 and was paid an additional $381.23 for saw rental.

Claimant filled out an 801 form and submitted it to the employer on July 23, 1987. The employer completed its portion of the form and erroneously reported claimant's average weekly wage as $171.90. The insurer began paying temporary total disability compensation (TTD) at the rate of $114.61 per week based upon this error. Within a couple of months, the insurer discovered the employer's mistake and reduced claimant's weekly TTD rate to $50. Claimant requested a hearing.

FINDINGS OF ULTIMATE FACT

Claimant's average weekly wage between February 1, 1987 and the date of the injury was $63.17.

CONCLUSIONS OF LAW

In computing claimant's TTD rate, the Referee excluded the payments made to claimant for saw rental and applied the formula prescribed in former OAR 436-60-020(4)(b). Claimant contends that the Referee should not have excluded the saw rental payments and should have computed his TTD rate under the formula set forth in former ORS 656.210(2).

Under former ORS 656.210(1), a worker who is temporarily totally disabled due to a compensable injury is to receive "compensation equal to 66-2/3 percent of wages." "Wages" is defined in ORS 656.005(26) as "the money rate at which the service rendered is recompensed under the contract of hiring in force at the time of the accident, including reasonable value of board, rent, housing, lodging or similar advantage received from the employer, and includes . . . tips."

We agree with the Referee that the payments made by the employer for saw rental were not "wages" and must be excluded from the computation of claimant's TTD rate. Those payments were made to claimant to cover the expense of operating his saw, not to recompense him for any services rendered. William P. Maloney, 38 Van Natta 213 (1986).

Regarding claimant's second argument, we conclude that he was not "regularly employed" within the meaning of former ORS 656.210(2). He was not required to work or to be available for work on any regular basis; he set his own days and hours of work. In addition, even if claimant were "regularly employed," the second paragraph of former ORS 656.210(2) authorized the Director to prescribe methods for establishing the weekly wage of "workers . . . whose remuneration is not based solely upon daily

or weekly wages." Claimant's remuneration was based on production, not on daily or weekly wages. The Director promulgated former OAR 436-60-020(1)(b) to cover workers paid on a piecework basis. The Referee, therefore, correctly applied that rule.

Former OAR 436-60-020(4)(b) provides that the wage rate of a worker employed on a piecework basis should be calculated according to the formula set out in paragraph (a) of the same subsection. That formula is as follows:

> "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."

Claimant was injured on July 20, 1987. Counting back 26 weeks from that date yields a date of January 19, 1987. Claimant made $440 as wages in January 1987. The record, however, does not reflect how much of that sum was earned before the 19th of the month and how much was earned afterward. It is impossible to compute claimant's average weekly wage accurately, therefore, for the full 26 weeks prior to his injury. The record does reflect, however, that between February 1, 1987 and the date of his injury claimant made a total of $1,524.90 in wages. February 1, 1987 falls 24 weeks and one day prior to the injury. Dividing $1,524.90 by 24.14 weeks equals an average weekly wage of $63.17. 66 and 2/3 of that figure equals a weekly TTD rate of $42.11. That falls below the minimum weekly rate of $50 established by former ORS 656.210(1). The employer, therefore, correctly paid claimant's TTD at the rate of $50 per week.

ORDER

The Referee's order dated February 8, 1988 is affirmed. A client-paid fee of up to $673.50 is approved.

A.V. MATTHEWS, Claimant
Pozzi, et al., Claimant's Attorneys
Cummins, et al., Defense Attorneys

WCB 85-04171
August 15, 1989
Order on Review

Reviewed by Board Members Crider and Ferris.

Claimant requests review of those portions of Referee Brown's order that: (1) declined to grant permanent total disability; and (2) affirmed a Determination Order that awarded no permanent disability. The self-insured employer cross-requests review of that portion of the order that set aside its denial of claimant's medical services claim for psychiatric treatment.

ISSUES

1. Extent of permanent disability, including permanent total disability.
2. Compensability of psychiatric treatment.

We affirm and adopt on the extent of disability issue, with the supplemental finding of ultimate fact below. We reverse on the compensability of treatment issue.

FINDINGS OF FACT

Claimant has been treating for emotional stress and anxiety since 1973. He suffers from chronic anxiety and a mixed personality disorder with passive-aggressive, passive-dependent and histrionic behavior. Claimant treated with Dr. Martin, a psychiatrist, on four occasions from April through June 1987. Martin submitted his bill for treatment to the employer. On July 8, 1987, the employer denied the claim on the ground that the need for treatment did not result from the compensable injury of April 1980.

FINDINGS OF ULTIMATE FACT

We do not find that the compensable injury of April 1980, materially contributed to either claimant's need for psychiatric treatment or her current disabling complaints.

CONCLUSIONS OF LAW AND OPINION

To establish the compensability of medical treatment, claimant must prove that the compensable injury materially contributed to the need for treatment. ORS 656.245(1); Jordan v. SAIF, 86 Or App 29, 32 (1987). Dr. Martin, the treating psychiatrist, offered the only opinion supporting the compensability of treatment. He diagnosed an adjustment reaction and related the condition to "the original back injury and reinjury and subsequent events with loss of income, loss of ability to do many of the things that he had done in the past." Dr. Parvaresh, on the other hand, diagnosed chronic anxiety tension state and a mixed personality disorder and opined that the April, 1980, injury did not contribute to the need for psychiatric treatment. Parvaresh explained that he could not find any temporal relationship between the 1980 injury and the need for treatment in 1987. He observed, however, that stressful events in claimant's life could precipitate an increase in nervousness and anxiety.

The Referee cited Parvaresh's observation above and essentially theorized that claimant's receipt of the Notice of Hearing in this case could have precipitated an adjustment reaction requiring Dr. Martin's treatment. He then concluded that treatment was compensable. We disagree for two reasons. First, the Referee's theory of causation is not supported by medical evidence. Second, the temporal relationship between receipt of the Notice of Hearing in January 1987, and the commencement of treatment in April 1987, is too tenuous to support a finding of causation.

After reviewing the psychiatric evidence above, we are most persuaded by Parvaresh's opinion. Although we ordinarily give greater weight to the opinion of the treating physician, see Weiland v. SAIF, 64 Or App 810, 814 (1983), we decline to do so here. A review of Martin's report shows that he relied on history supplied by claimant and apparently knew nothing of claimant's prior treatments for psychological problems. Indeed, Martin reported that he had insufficient information to establish the presence of a personality disorder. Moreover, it is unclear from Martin's opinion whether he was relating the need for treatment to the 1980 injury or to a prior industrial or nonindustrial injury. That lack of specificity, as well as the limited history available

to Martin, render his opinion unpersuasive. Parvaresh's opinion was thorough and well-reasoned. See Somers v. SAIF, 77 Or App 259, 263 (1986). Accordingly, we do not find that the compensable injury of April, 1980, materially contributed to claimant's need for psychiatric treatment.

ORDER

The Referee's order dated January 22, 1988, as reconsidered on February 26, 1988, is reversed in part and affirmed in part. The self-insured employer's medical services denial of July 8, 1987, is reinstated and upheld. The Referee's attorney fee award for prevailing over the denial is disallowed. The remainder of the order is affirmed. The Board approves a client-paid fee not to exceed $2,500.

ERICA E. MORENO, Claimant
Ridgway Foley, Attorney

WCB 87-02937
August 15, 1989
Order on Review

Reviewed by Board Members Ferris and Crider.

Claimant, pro se, requests review of that portion of Referee Livesley's order that upheld a Director's order which denied her further vocational assistance. The self-insured employer cross-requests review of that portion of the Referee's order requiring it to pay 50 percent of a bill for medical services performed by Dr. Holcomb.

We affirm and adopt that portion of the order of the Referee which concerns the vocational assistance issue. Regarding the medical services issue, we adopt the Referee's findings with the following additional findings of fact and modification.

The Referee ordered the employer to pay 50 percent of the bill for Dr. Holcomb's services. There is support for the Referee's decision. See Patricia J. Hammett, 35 Van Natta 642, 648-49 (1983); Virginia Hamilton, 31 Van Natta 14, 16 (1981). However, we prefer another approach.

Claimant was examined by Dr. Holcomb for three basic reasons: (1) a gynecological exam, including pap smear and mammograms; (2) low back and hip pain treatment; and (3) an opinion regarding the etiology of her hip pain and its relationship to her compensable low back condition. Dr. Holcomb examined claimant for these purposes on October 27, 1986. He saw claimant again on January 8, 1987. Finally, on January 12, 1987, Dr. Holcomb authored a report at the request of the employer's counsel. In that report, Dr. Holcomb opined that claimant's hip pain was unrelated to her compensable injuries.

Under these circumstances, we conclude that those portions of claimant's October 27, 1986 and January 8, 1987 examinations and evaluations which pertained to her low back and hip were reasonable, necessary and attributable to her compensable injuries. In reaching this conclusion, we note that diagnostic procedures which are reasonable and necessary to determine a causal relationship, if any, between a condition and a compensable injury are compensable, even if the condition is ultimately determined not compensable. Brooks v. D & R Timber, 55 Or App 688, 691-92 (1982); Kenneth M. Simons, 41 Van Natta 378, 380 (1989).

Accordingly, we hold that the employer is responsible for that portion of Dr. Holcomb's bill which concerns the aforementioned low back and hip exams/evaluations. Inasmuch as the gynecological exam, pap smear, and mammography were not administered to determine a causal relationship between claimant's gynecological conditions and her compensable injuries, the employer is not responsible for those portions of Dr. Holcomb's bill that pertains to those services.

ORDER

The Referee's order dated December 28, 1987 is affirmed and modified. In lieu of the Referee's direction to pay 50 percent of Dr. Holcomb's bill, the employer is directed to pay those portions of the bill which pertain to the services that have been found compensable herein. The remainder of the Referee's order is affirmed. A client-paid fee, payable from the self-insured employer to its counsel, is approved, not to exceed $1,736.50.

KENNETH W. MYERS, Claimant
Emmons, et al., Claimant's Attorneys
Ronald E. Rhodes, Defense Attorney

WCB 87-00812
August 15, 1989
Order on Review

Reviewed by Board Members Ferris and Crider.

Claimant requests review of those portions of Referee Black's order that: (1) denied claimant's request for temporary total disability compensation for the period February 22, 1985 to September 5, 1985; and (2) increased claimant's unscheduled permanent disability award for a back injury from 30 percent (96 degrees), as awarded by a Determination Order, to 50 percent (160 degrees). The insurer cross-requests review of the Referee's award of additional permanent partial disability, asserting that the award was excessive. The issues are entitlement to additional temporary and permanent partial disability compensation. We affirm.

Upon our initial review of the record, we noted the absence of several exhibits which were admitted at hearing. We concluded that omission of the exhibits constituted an improper, incomplete, or otherwise insufficient development of this case. See ORS 656.295(5). Therefore, we remanded to the Presiding Referee for purposes of inclusion of the exhibits in the record on review. The exhibits have since been included in the record. We now proceed to a review on the merits.

FINDINGS OF FACT

Claimant, a 31-year-old laborer, sustained a compression fracture in April 1983, when he fell about 15 feet from a scaffold while erecting a tent. Claimant returned to work with the same employer and performed some light production tasks in the summer of 1983. Claimant was off work again in October 1983. He returned to work in a light-duty vehicle maintenance position with the employer in January 1984.

His claim was first closed by Determination Order dated April 5, 1984, wherein he was declared medically stationary as of February 21, 1984. Pursuant to the Determination Order, he was awarded 30 percent unscheduled permanent disability. Claimant requested a hearing to appeal the Determination Order.

Claimant continued to work successfully at the light-duty vehicle maintenance position until he was laid off at the end of February 1985.

On May 23, 1985, Dr. Moore, on referral from claimant's then treating physician, Dr. Atkinson, recommended that claimant obtain a YMCA membership to allow him to recondition himself.

In September 1985, the parties entered into a stipulated agreement wherein claimant reserved the right to raise any issues which could have been raised at a pending hearing on the April 5, 1984 Determination Order.

Claimant did not work until September 1986, at which time he was employed with an auto service and parts firm pursuant to an authorized training program. This program resulted in full time work as a parts counter person and service writer at a current monthly salary which is comparable to his last work with the employer-at-injury.

Claimant's authorized training program ended on September 3, 1987. A December 23, 1987 Determination Order awarded temporary disability for the period of his training program but no further permanent disability beyond that awarded by the April 5, 1984 Determination Order. Claimant requested a hearing on the Determination Order.

Claimant experiences daily discomfort if he overexerts. His symptoms include radiating pain into the cervical area causing headaches and stiffness; alternate burning and numbness between the shoulder blades; pain in the mid-thoracic area and radiating pain in the left costal margin with chronic popping and pain in the ribs; numbness in the fingers and elbows, and sudden spasms; and sensations of his feet and legs occasionally going to sleep or weakness in the knees. These problems have been chronic since his injury.

Claimant's limitations are: no continuous activity (sitting, standing, driving, walking) for more than a half hour without some discomfort, and not more than an hour without serious discomfort; he cannot do any repetitive twisting or bending and can lift or carry no more than 10 pounds. As a result of these limitations, he is now restricted to light work.

Claimant had worked prior to the injury essentially in heavy labor. Although now in possession of a GED, he finished only the ninth grade. His former jobs were in warehouse work, meat packing, sheetrock installation, gas station duties, cannery (forklift and sanitation), farm work (mechanics and irrigation), and groundskeeping and fast food cooking. In order to satisfactorily perform his current job, he requires extra breaks, shifting assignments, and he occasionally misses work altogether, being permitted to make up time on Saturdays.

FINDINGS OF ULTIMATE FACTS

Claimant was medically stationary as of February 21, 1984.

Claimant's compensable condition did not worsen on or after April 5, 1984.

CONCLUSIONS OF LAW AND OPINION

Temporary Disability

Claimant argues entitlement to additional temporary disability for the period between March 1, 1985, his last day of work with the employer, and commencement of his authorized training program on September 5, 1985. The grounds upon which claimant alleges entitlement to additional temporary compensation are not entirely clear. Claimant's primary contention appears to be that he was not medically stationary at the time of the April 5, 1984 Determination Order. This is a premature closure argument. See ORS 656.268(1). However, claimant also asserts in his brief that, as of March 1, 1985, he was less able to work than he had previously been. This is an aggravation argument. See ORS 656.278; Smith v. SAIF, 302 Or 396 (1986). We conclude, however, that claimant is not entitled to the requested relief under either a premature closure or an aggravation analysis.

(1) Premature Closure.

Claims shall not be closed if the worker's compensable condition has not become medically stationary. ORS 656.268(1). An injured worker will be considered medically stationary when no further material improvement would reasonably be expected from medical treatment or the passage of time. ORS 656.005(17).

Two physicians expressed opinions regarding claimant's medically stationary status: Dr. Atkinson and Dr. Moore. On March 15, 1985, Dr. Atkinson reported that claimant was not medically stationary. However, it does not appear that Dr. Atkinson understands the statutory concept of medically stationary. For example, on December 15, 1986, Dr. Atkinson reports that claimant is not medically stationary "because of his continued symptomatology." (Emphasis supplied). Similarly, he reported on June 11, 1987 that "[p]erhaps semantically his original injuries were stationary but the sequelae from that injury were not stationary and were continuing." (Emphasis supplied). We are left to conclude that Dr. Atkinson believes that a history of ongoing symptoms is inconsistent with medically stationary status. This is incorrect. See Maarefi v. SAIF, 69 Or App 527 (1984) (fluctuating symptoms and/or need for continuing medical treatment does not defeat medically stationary status). We conclude that Dr. Atkinson's opinion is unpersuasive.

Turning next to Dr. Moore, he reported on May 23, 1985 that claimant was medically stationary, albeit badly deconditioned. He then changed his opinion and, on February 26, 1987, he reported to claimant's attorney that claimant was not medically stationary between February 22, 1985 and September 4, 1985. He offered no explanation for this changed opinion. Then, on July 17, 1987, Dr. Moore stood by his May 23, 1985 statement that claimant was medically stationary at that time. We conclude that Dr. Moore does not support claimant's position.

Claimant argues on review that he was undergoing further diagnostic tests, evaluation, and physical therapy during the period in question. However, claimant has undergone physical therapy periodically since his injury. The record of that treatment establishes that this physical therapy was palliative in

nature rather than curative. In this regard, a need for additional diagnostic and palliative measures does not preclude medically stationary status. Monte B. Francis, 38 Van Natta 9 (1986).

Claimant also contends that Dr. Moore's May 23, 1985 referral to the YMCA establishes that he was not medically stationary. We do not agree. It is claimant's condition at the time of closure without respect to subsequent changes in his condition that is decisive of whether a claim has been prematurely closed. Schuening v. J. R. Simplot & Co., 84 Or App 622, rev den 303 Or 590 (1987). Dr. Moore referred claimant to the YMCA due to the fact that he was "very badly deconditioned and badly in need of a program to allow him to recondition in spite of the pain." This medical finding of severe deconditioning was made more than one year following issuance of the April 15, 1984 Determination Order. We are unable to find, based upon the May 23, 1985 YMCA referral, that it was reasonable to expect that claimant's condition was amenable to further curative treatment as of the date of closure.

(2) Aggravation.

Claimant also argues that his condition worsened to the point where he was less able to work. Claimant and his wife both testified to a worsened condition. The Referee found both claimant and his wife credible with regard to their description of the everyday extent of claimant's symptoms. However, he did not find their testimony regarding worsened symptoms to be persuasive. He found in this regard that no medical evidence supported a finding of a worsened condition. We agree. Our review of the record persuades us that claimant experiences ongoing symptoms of his compensable condition. We are not persuaded that claimant has experienced a worsening of that condition, either temporary or permanent. Thus, he has not proven a compensable aggravation claim. See Perry v. SAIF, 307 Or 654 (1989).

Extent of Permanent Disability

The Board adopts the Referee's opinion on this issue.

ORDER

The Referee's order dated October 2, 1987 is affirmed. For prevailing against the insurer's cross-request for review on the issue of permanent partial disability, claimant's attorney is awarded a reasonable attorney fee of $600, to be paid by the insurer.

ANDREY SANAROV, Claimant
Gatti, et al., Claimant's Attorneys
David O. Horne, Defense Attorney

WCB 86-04694
August 15, 1989
Order on Review

Reviewed by Board Members Ferris and Crider.

The insurer requests review of that portion of Referee Nichols' order that set aside its partial denial relating to claimant's neck and low back. Claimant raises the issue of extent of disability on Board review. We affirm.

ISSUES

1. The partial denial relating to claimant's neck and low back.

2. Whether the Board should address the issue of extent of disability. If so, the extent of unscheduled disability for claimant's neck, mid back and low back.

FINDINGS OF FACT

Claimant sustained injuries to his head and back on May 1, 1985 in the course of his employment as a tree thinner when he was hit on the head by a falling limb or snag. Claimant was wearing a hardhat at the time of the accident and was leaning forward slightly, operating a chainsaw. The blow knocked him to the ground and rendered him unconscious for a short time.

Claimant was taken to an emergency room and underwent physical and x-ray examinations. The examining doctor noted severe pain in claimant's mid back, neck tenderness, a headache, a chipped tooth and a tongue abrasion. X-rays revealed moderately severe compression fractures of T5 and T6. After a few days in the hospital for observation, claimant was released to the care of Dr. Schader, an orthopedic surgeon.

Dr. Schader first saw claimant on May 6, 1985. He performed a physical examination and questioned claimant about his symptoms. He recorded no head, neck or low back complaints. He diagnosed compression fractures of the thoracic spine and recommended that claimant remain off work for a period of time. He prescribed Tylenol #3 for pain and monitored claimant's progress in monthly follow-up examinations.

Claimant continued to experience mid back and neck pain after his initial meeting with Dr. Schader. Several weeks later, a month or so after the accident, claimant also began to experience pain in his low back. On August 27, 1985, claimant began treating with a chiropractor, Dr. Schmidt. Dr. Schmidt noted symptoms throughout claimant's thoracic region and began a course of frequent chiropractic manipulations.

During mid 1986, claimant left Oregon and went to Alaska. There, he worked without pay for a short time on a fishing boat owned by his brother. This work resulted in an increase in back pain and claimant received several treatments from an Alaska chiropractor. In August 1986, claimant returned to Oregon and resumed treatment with Dr. Schmidt. In February 1987, claimant was involved in an automobile accident which resulted in a temporary increase in neck pain. Claimant's claim was closed by Determination Order in May 1987 with an award of 25 percent unscheduled permanent partial disability.

The insurer issued its partial denial relating to claimant's neck and low back in September 1987.

Claimant timely filed a request for hearing on the insurer's partial denial and later filed a supplemental hearing request on the May 1987 Determination Order. At the beginning of the hearing, the parties agreed that if the insurer's partial denial was upheld, the Referee would address the issue of extent

of disability. If the partial denial was set aside, the parties agreed to reserve the issue of extent of disability for later litigation. The Referee set aside the insurer's partial denial and, in accordance with the agreement of the parties, did not address the issue of extent of disability.

Before the May 1985 industrial accident, claimant had injured his low back in January 1985 in the course of his employment with a previous employer. Claimant experienced radiation of pain into his left buttock in connection with this injury. The injury had resolved and was asymptomatic by April 1985. The claim for the injury was closed by notice of claim closure on April 30, 1985.

FINDINGS OF ULTIMATE FACT

1. Claimant injured his neck and low back as well as his mid back in the May 1985 accident. The neck and low back injuries continue to be a material contributing cause of claimant's disability and need for medical services.

2. The parties reserved the issue of extent of disability for later litigation.

CONCLUSIONS OF LAW

1. The Partial Denial of Claimant's Neck and Low Back Conditions

The Referee set aside the insurer's partial denial of claimant's neck and low back conditions. On Board review, the insurer contends that claimant did not injure his neck or low back in the May 1985 industrial accident and attempts to attribute claimant's symptoms in those areas to other causes including claimant's prior industrial injury, his work in Alaska and his automobile accident.

To establish the compensability of his neck and low back conditions, claimant has the burden of proving that the May 1985 industrial accident was a material contributing cause of disability or a need for medical services in those areas. See Harris v. Albertson's, Inc., 65 Or App 254, 256-57 (1983). "Material contributing cause" means a substantial cause, but not necessarily the sole or even the most significant cause. See Lobato v. SAIF, 75 Or App 488, 492 (1985).

There are two primary opinions regarding the relationship between claimant's May 1985 industrial accident and his subsequent neck and low back complaints. Dr. Schader, claimant's former treating orthopedic surgeon, opined that claimant had not injured his neck or low back in the 1985 industrial accident. Dr. Schmidt, claimant's current treating chiropractor, opined that the accident had injured claimant's neck and low back and that these injuries are adversely affected by the mid back injury whenever it flares up. After considering these opinions and the circumstances of this case, we conclude that the opinion of Dr. Schmidt is more persuasive than that of Dr. Schader.

Both Schmidt and Schader agree that the trauma which claimant experienced as a result of the May 1985 accident was sufficient to cause injuries to claimant's neck and low back as well as his mid back. Claimant was struck on the top of the head with sufficient force to cause compression fractures in his mid

back. The force of the blow obviously was transmitted through claimant's neck and down his spine. The blow also knocked claimant to the ground. Claimant complained of neck soreness immediately after the accident and developed low back pain within a few weeks without any intervening injury. Claimant's neck and low back symptoms gradually worsened as claimant became more active following the initial recovery period. Claimant's neck and low back were asymptomatic immediately before the accident. Given these facts, the inference that the May 1985 accident injured claimant's neck and low back as well as his mid back is strong.

Dr. Schader's conclusion that claimant did not sustain injuries to his neck and low back was based primarily upon the fact that he did not record any neck or low back complaints during his early meetings with claimant. We do not find this surprising. The obvious focus of Schader's early treatment was the relatively severe injury to claimant's mid back. Other complaints were understandably overlooked during the infrequent meetings between Schader and claimant. In addition, the inactivity and medication associated with the mid back injury would tend to mask the neck and low back injuries. In short, we do not find Dr. Schader's failure to record neck and low back complaints soon after the accident fatal to claimant's case.

Claimant's physical activity in Alaska during 1986 and the automobile accident in February 1987 resulted in exacerbations of his low back and neck conditions. Dr. Schmidt indicated that the May 1985 injuries were material contributing causes of the worsened conditions during these exacerbations. Claimant credibly testified that the exacerbations were temporary in nature and that his condition subsequently returned to the baselines established by the May 1985 accident. Given these facts, we conclude that the exacerbations did not sever the compensable causal relation between the May 1985 accident and claimant's neck and low back conditions. See Grable v. Weyerhaeuser Co., 291 Or 387, 400-01 (1981). The insurer's partial denial shall be set aside.

2. Extent of Disability

The parties agreed to reserve the issue of extent of disability for later litigation if claimant prevailed against the insurer's partial denial. The Referee set aside the denial and thus did not address the extent issue. Claimant now requests that the Board decide the issue. In view of the agreement of the parties and the fact that the extent issue was not presented to or decided by the Referee, the Board declines to address it.

ORDER

The Referee's order dated December 23, 1987 is affirmed. For services on review concerning the partial denial issue, claimant's attorney is awarded $550, to be paid by the insurer.

JOEL L. WHITMORE, Claimant
S. David Eves, Claimant's Attorney
John Motley (SAIF), Defense Attorney

WCB 88-13255
August 15, 1989
Order on Review

Reviewed by Board Members Crider and Ferris.

The SAIF Corporation requests review of Referee Foster's order that increased claimant's unscheduled permanent disability award for a psychological condition from 16 percent (51.20 degrees), as awarded by a Determination Order, to 40 percent (128 degrees). SAIF contends on review that the award was excessive. We modify.

FINDINGS OF FACT

Claimant was 33 years of age at hearing. On February 16, 1987, while working as a timber faller, claimant felled a tree which struck and killed a co-worker. Following the incident, claimant experienced anxiety and depression. He attempted to return to work on March 3, 1987, but his anxiety level was too great to permit him to work effectively. Claimant's family physician, Dr. Nelson, released claimant from work for ten days.

On March 10, 1987, claimant's job replacement felled a tree which struck and killed a personal friend of claimant. Claimant felt that if he had been at work, the accident would not have occurred. Consequently, he blamed himself for this death. Claimant's father had previously been killed in a logging accident when claimant was two years old. The two recent deaths, coupled with his father's prior death, resulted in the onset of an unresolved grief disorder characterized by depression, anxiety, insomnia, nightmares and irritability. These symptoms resulted in a one-day psychiatric hospitalization.

During the ensuing months, claimant received periodic psychological counseling and had medication prescribed. Claimant's overall condition improved. However, he experienced significant anxiety symptoms whenever he was in the woods or around people or objects that reminded him of logging.

Dr. Nelson subsequently referred claimant to Dr. Kuttner, psychiatrist, in September 1987. Dr. Kuttner provided counseling and adjusted claimant's medications. Claimant began to look for employment outside of the logging industry.

On February 24, 1988, Dr. Kuttner released claimant for modified work; the modification being the exclusion of logging activities. Approximately two weeks later, claimant obtained employment as a machine operator. His wage at the time of hiring was $5.50 per hour. By the date of hearing, claimant was earning approximately $9.00 per hour. The top wage scale for his current job is approximately $11.00 per hour. His wage at the time of the February 1987 incident was $108.00 per day, plus approximately $30.00 per day because he provided his own chain saw.

Claimant was medically stationary as of May 9, 1988.

On July 14, 1988, a Determination Order issued. Claimant was awarded 16 percent unscheduled permanent disability.

Claimant suffers from a post-traumatic stress disorder caused by the February 1987 incident which has resulted in a phobic avoidance of logging. As a result of this disorder he is permanently unable to return to work in the logging industry. He is otherwise functioning on a good level with only some residual anxiety and nightmares of a nondisabling degree. He no longer requires regular psychotherapy. He continues to take medication.

Claimant has completed the 9th grade and has no GED. In addition to working as a tree faller, claimant has also worked as a choker setter, rigger, and skidder operator. Outside of the logging industry, claimant worked on a ranch more than ten years ago. The highest specific vocational preparation value for the jobs claimant has performed for the last ten years is timber faller, which is 6. Claimant has received no specific vocational training. Prior to the February 1987 incident, claimant performed heavy work. His current employment as a machine operator involves medium work.

CONCLUSIONS OF LAW AND OPINION

In determining the extent of claimant's permanent disability, the Referee applied the standards for evaluating permanent disability as adopted by the Director for the Department of Insurance and Finance pursuant to ORS 656.726(3)(f). See ORS 656.283(7). Specifically, the Referee applied former OAR 436-35-000 et seq, which were effective at the time of the July 14, 1988 Determination Order. See OAR 438-10-005; 438-10-010. These are the rules which we apply as well. Id.

The Referee increased claimant's unscheduled permanent disability award for his psychological condition from 16 percent to 40 percent. We agree that the Determination Order award was insufficient. We find, however, that the Referee's award of 40 percent is excessive.

Impairment

The criteria to be used in rating the impairment resulting from a permanent state of mental disorder are found at former OAR 436-35-400. Mental disorders are there subdivided into personality disorders, psychoneuroses and psychosis conditions. The medical evidence establishes that the post-traumatic stress disorder from which claimant suffers takes the form of a psychoneurosis. Psychoneuroses are, in turn, subdivided into three "classes" depending upon the severity and duration of the symptoms.

None of the medical experts in the record have offered an opinion as to which class of psychoneurosis claimant's compensable condition falls. The Referee concluded in this regard that claimant's impairment borders between a Class 2 and Class 3 rating. SAIF contends that claimant's impairment corresponds to a Class 1 rating.

Claimant's disorder becomes apparent when he is placed in a situation which reminds him of his logging activities. Claimant need not be around actual logging activities to trigger the onset of the symptoms of his disorder. For example, as simple an activity as taking a walk in the woods can cause the appearance of symptoms. During such times, claimant experiences

significantly heightened anxiety to the degree that continued functioning is difficult. In addition, claimant has a phobic reaction to such situations involving a belief that he is a "jinx" and, consequently, a danger to others. This phobic reaction interferes with numerous normal activities, for example woodcutting, to a moderate degree. Furthermore, exposure to circumstances reminiscent of logging activities results in insomnia and nightmares. While claimant no longer requires regular psychiatric care, he continues to require medication. Moreover, Dr. Kuttner has left open the possibility that claimant may require extended treatment in the future.

Comparing these symptoms to the various classes of psychoneuroses defined in the rule, we are persuaded that claimant's impairment is properly placed in the Class 2 rating. Former OAR 436-35-400(4)(b). In particular, claimant's insomnia, phobia, inability to work well with others, and anxiety reactions when placed in a wooded setting all meet the criteria established by a Class 2 rating. Id. However, in recognition of the fact that the symptoms of claimant's psychoneurosis appear only under certain narrowly defined circumstances, we conclude that claimant's impairment is within the lower range of the Class 2 rating. Accordingly, we assign a value of 20.

Age

No value is assigned for workers who have returned to their regular work, refused their regular work after release to regular work by the attending physician or who are 39 years old or younger. OAR 436-35-290(1), (2), and (3). Here, claimant was 33 years of age at hearing. Consequently, his age value is zero. OAR 436-35-290(4).

Education

Formal education. No value is assigned for workers who have returned to their regular work, refused their regular work after release to regular work by the attending physician or who have a high school education, GED certificate or more education. OAR 436-35-300(2). Here, none of the aformentioned conditions apply. Claimant has a 9th grade education and no GED. Therefore, his formal education value is +1.

Skills

No value is assigned for workers who have returned to their regular work or refused their regular work after release to regular work by the attending physician. OAR 436-35-300(2). Claimant has not been released to his regular work nor has he returned to his regular work. OAR 436-35-300(4) provides the values assigned to the various specific vocational preparation (SVP) levels, obtained with reference to the Dictionary of Occupational Titles and applicable supplements. Claimant's highest SVP in the last 10 years is as a timber faller (6), which is assigned a value of +2.

Training

No value is assigned for workers who have returned to their regular work or refused their regular work after release to regular work by the attending physician. OAR 436-35-300(2).

These conditions are not applicable to claimant. If no documentation demonstrating competence in some specific vocational pursuit is present, a value of +1 is assigned. Former OAR 436-35-300(5)(a). Inasmuch as no documentation of such training was provided, a value of +1 is assigned.

All the education factors are added for a total value of +4. OAR 436-35-300(5)[sic].

Adaptability to perform a given job

No value is assigned for workers who have returned to their regular work or refused their regular work after release to regular work by the attending physician. OAR 436-35-310(1). When workers are unable to return to their usual and customary work, but have returned to modified work, the value for this factor shall be based on the difference between the physical capacity necessary to perform the usual and customary work and the physical capacity required to perform the modified job according to a table provided in OAR 436-35-310(3)(a).

Here, claimant's work at injury was heavy. Thereafter, he returned to work as a machine operator which is a medium capacity employment. Accordingly, the adaptability value is +2.

Assembling the factors

The age value is added to the total value for education. (0 + 4 = 4). OAR 438-35-280(4). The sum of the values for age and education are multiplied by the value for adaptability. (4 x 2 = 8). OAR 438-35-280(6). The product of the values for age/education and adaptability is added to the total impairment value to reach the percentage of permanent unscheduled permanent disability to be awarded. (8 + 20 = 28). OAR 438-35-280(7). Accordingly, we conclude that claimant is entitled to an unscheduled permanent disability award of 28 percent under the standards.

Clear and Convincing Evidence

Neither party is prevented or limited from establishing by clear and convincing evidence that the degree of permanent disability suffered by the claimant is more or less than the entitlement indicated by the standards adopted by the Director under ORS 656.726. See ORS 656.283(7); 656.295(5). To be "clear and convincing," evidence must establish that the truth of the asserted fact is "highly probable." Riley Hill General Contractor v. Tandy Corporation, 303 Or 390, 402 (1987).

Here, claimant asserts that the opinion of his vocational expert, Mr. McNaught, establishes by clear and convincing evidence that 16 percent as awarded by the Determination Order was inadequate. He argues that McNaught's evidence supports the Referee's award of 40 percent. Comparing claimant's wages at the time of his injury with his post-injury wages, McNaught opined that claimant's loss of earning capacity was greater than that reflected in the prior award.

Although McNaught's opinion is probative, we are not persuaded that it establishes by clear and convincing evidence that claimant's loss of earning capacity is greater than that we

have hereby awarded under the standards. Since commencing employment as a machine operator, claimant has experienced a steady growth in earnings. In this regard, whereas McNaught believed that claimant was earning $5.00 per hour in his new job and assumed it was unlikely he was capable of earning more without education or training, he was in fact earning $9.00 per hour.

In addition, compensation is due for loss of "earning capacity" rather than merely loss of earnings. The record establishes in this regard that claimant can reasonably expect to receive continued salary increases approaching the point where he is earning the same salary as he was at the time of injury. Moreover, there is no persuasive evidence in the record that claimant's current employment is in any sense unique in this regard. In conclusion, claimant has not established by clear and convincing evidence that his loss of earning capacity is greater than that reflected in an award of 28 percent unscheduled permanent partial disability.

Attorney Fee

In his brief on review, claimant argues he is entitled to a carrier-paid attorney fee if we should affirm the July 14, 1988 Determination Order. Instead, we are increasing the award contained in the Determination Order. Implicitly, claimant argues he is entitled to a carrier-paid fee under this circumstance. ORS 656.382(2) provides for a carrier-paid fee where two conditions are met. First, the request for hearing or review must be initiated by the carrier. Second, the adjudicator must find that the compensation awarded to claimant "should not be disallowed or reduced." Here, SAIF requested review. However, pursuant to our order, claimant's compensation as awarded by the Referee will be reduced. Therefore, claimant is not entitled to a carrier-paid attorney fee.

ORDER

The Referee's order dated November 10, 1988 is modified. In lieu of the Referee's award and in addition to the 16 percent (51.2 degrees) unscheduled permanent disability awarded by Determination Order, claimant is awarded 12 percent (38.4 degrees) unscheduled permanent disability, giving him a total award to date of 28 percent (89.6 degrees) unscheduled permanent disability for his psychological condition. Claimant's attorney fee shall be adjusted accordingly.

MARIA P. GONZALEZ, Claimant
Eveleen Henry, Claimant's Attorney
Ridgway Foley, Defense Attorney

WCB 85-08859
August 17, 1989
Order on Review

Reviewed by Board Members Ferris and Crider.

Claimant requests review of Referee Nichols' order that: (1) upheld the insurer's partial denial relating to her shoulders; (2) rejected her request for a penalty and associated attorney fee for unreasonable denial of the above conditions; and (3) increased her award of unscheduled permanent partial disability for her neck from the 55 percent (176 degrees) awarded by Determination Order to 70 percent (224 degrees), but rejected her request for an award of permanent total disability. In its respondent's brief, the insurer contends that the Referee erred in

setting aside its partial denial relating to claimant's neck. The issues are the compensability of claimant's shoulder and neck conditions, penalties, attorney fees and extent of disability.

The Board adopts the Referee's findings of fact and conclusions of law with the following additions.

ADDITIONAL FINDINGS OF FACT

Claimant is limited to light or sedentary work. She speaks Spanish, but does not speak, read or write English well. She is unable to drive an automobile. The insurer referred claimant for vocational assistance in August 1985. The vocational counselor determined that an authorized training program would be necessary and began searching for opportunities for on-the-job training. Eventually an employer, who expressed considerable interest in training claimant, was located. The job was within claimant's physical limitations and the employer's premises were within walking distance of claimant's home. The employer also spoke Spanish.

While the vocational counselor was attempting to arrange a meeting between himself, claimant and the employer, claimant visited the employer's premises herself. While there, she told the employer that she was not really interested in working for the employer and that she felt like she was being pressured to take the job. After that, the employer refused to consider claimant further for the position. Claimant's vocational assistance was then terminated. Claimant did not challenge the termination.

Claimant is not willing to seek regular gainful employment and has not made reasonable efforts to obtain such employment.

ADDITIONAL CONCLUSIONS OF LAW

Claimant's opportunities for employment are severely restricted by her physical limitations, her inability to communicate in English and her transportation problems. Nonetheless, the vocational counselor was able to find a job within these restrictions. Claimant then sabotaged this position by expressing a lack of motivation to the potential employer. Under these circumstances, we agree with the Referee that claimant has failed to demonstrate a willingness to obtain regular gainful employment or made reasonable efforts in that direction.

ORDER

The Referee's order dated March 23, 1988 is affirmed. Claimant's attorney is awarded $200 for services on Board review in connection with the partial denial relating to her neck, to be paid by the insurer. A client-paid fee, payable from the insurer to its counsel, of up to $1,624 is approved.

RACHID KAADY, Claimant
Paul Rask, Claimant's Attorney
Pozzi, et al., Attorneys
Schwabe, et al., Attorneys
Cooney, Moscato & Crew, Attorneys
Michael Kohlkoff, Attorney
Acker, Underwood, et al., Attorneys

WCB TP-89004
August 17, 1989
Third Party Distribution Order

EBI Companies, a purported paying agency, has petitioned the Board to resolve a dispute concerning a third-party settlement. See ORS 656.587, 656.593. EBI contends that the settlement between claimant and the Professional Liability Fund (the "Fund" is the malpractice insurer for claimant's attorney in the third party lawsuit) is void for want of prior approval by EBI. In addition, EBI requests that we strike certain portions of the Fund's Motion to Consolidate filed in this case. The Fund, on behalf of claimant, argues that EBI has no lienable interest in the settlement proceeds.

We grant EBI's partial motioin to strike. However, on the merits, we conclude that EBI does not have a lien under the third party statutes. Therefore, the requested relief is denied.

FINDINGS OF FACT

Claimant, a deliveryman, suffered a low back injury on April 15, 1983, while lifting a televison for EBI's insured. EBI initially denied the claim, then later rescinded its denial.

Approximately two months later, on June 23, 1983, claimant was involved in an on-the-job automobile accident from which he suffered increased low back symptoms along with additional new symptoms. At the time of this automobile accident, Fireman's Fund had replaced EBI as the employer's workers' compensation carrier.

On February 15, 1984, EBI issued a denial of elbow and shoulder conditions arising from the automobile accident. The denial was not challenged.

Two years later, on May 1, 1985, claimant's then attorney requested a hearing listing dates of injury of April 15, 1983 and June 23, 1983, and EBI and Fireman's Fund as insurers. He did not specify the issues.

On June 19, 1985, claimant's attorney commenced a third party action against the owner and the driver of the other vehicle involved in the June 1983 motor vehicle accident.

On September 19, 1985, EBI denied continued responsibility for claimant's low back condition, contending that claimant had injured his low back in the June 23, 1983 motor vehicle accident. Claimant's attorney subsequently prepared a Request for Hearing challenging EBI's September 19, 1985 denial. This request was sent to EBI, but was not received by the Hearings Division.

On March 13, 1986, claimant's May 1, 1985 Request for Hearing was dismissed. No appeal was taken from this dismissal order.

Shortly thereafter, the third party defendants moved the

trial court to dismiss claimant's third party suit. The motion was granted by the trial court, and judgment was subsequently entered in favor of the third party defendants.

Thereafter, claimant asserted a legal malpractice claim against the attorney who had represented him both in the third party action and the workers' compensation matters. EBI subsequently notified claimant of its asserted lien as to any recoveries in the matter.

A Referee's order dated March 31, 1988 held, inter alia, that claimant had failed to timely appeal EBI's September 19, 1985 low back denial. No appeal was taken from that order.

On June 24, 1988, the Fund notified EBI that the malpractice action arising out of the third party claim had been settled by the parties for the sum of $10,000, and that a settlement of $20,000 had been reached with regard to the workers' compensation cases.

EBI subsequently petitioned the Board to resolve the dispute over its alleged entitlement to a share of the settlement proceeds.

On May 16, 1989, the Fund filed a Motion to Consolidate this case with two other cases. These other cases also raised questions involving alleged liens against proceeds resulting from legal malpractice settlements. In addition to its argument regarding consolidation, the Fund argued that EBI's lien, if any, should be limited to the $10,000 settlement entered into with regard to the third prty suit. With its motion, the Fund submitted as exhibits copies of the two settlement agreements arising out of the legal malpractice action. Exhibit "A" is a copy of the agreement settling clamant's malpractice claim relating to his workers' compensation claims. This exhibit was not submitted with the Fund's Memorandum of Opposition to EBI's Petition for Relief.

EBI objected to consolidation of the three cases. EBI also moved to have the Board strike those portions of the Fund's Motion for Consolidation which allegedly presented new arguments and which included the exhibit not previously submitted.

The Fund's request to consolidate the three cases was denied by the Board by letter dated June 5, 1989. EBI's motion to strike portions of the Fund's Motion for Consolidation was deferred until the time of review.

CONCLUSIONS OF LAW AND OPINION

Motion to Strike

By letter dated February 16, 1989, the Board established a briefing schedule for this matter. See former OAR 438-11-045. Pursuant to that briefing schedule, the Fund filed a memorandum in opposition to EBI's petition. EBI then filed a reply memorandum. Thereafter, the Fund filed it's Motion to Consolidate. However, the Fund's motion is not limited to arguing in favor of consolidation. Rather, the Fund's motion contains substantive argument regarding the merits of EBI's petition. This new argument was presented outside the briefing schedule and,

therefore, ws not timely presented. Our review will be limited to those arguments timely raised by the parties.

Moreover, no explanation has been provided as to why Exhibit "A" to the Fund's Motion to Consolidate could not have been submitted with the Fund's initial memorandum. We conclude that the exhibit was obtainable with due diligence at the time of filing of the Fund's initial memorandum. Therefore, the exhibit will not be considered. See Donald P. Bond, 40 Van Natta 361, 480 (1988).

Merits

If a worker receives a compensable injury due to the negligence or wrong of a third person not in the same employ, the injured worker may elect to seek a remedy against the third person. ORS 656.154, 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. In addition, any compromise of a third party action is void unless made with the written approval of the paying agency or, in the event of a dispute between the parties, by order of the Board. ORS 656.587. A "paying agency" is defined as "the self-insured employer or insurer paying benefits to the worker or beneficiaries." ORS 656.576.

Here, EBI contends that it is a "paying agency" for a compensable injury and that settlement of claimant's legal malpractice action represents a compromise of a third party action. Further, EBI argues that the settlement agreement is void because claimant did not first obtain EBI's written approval of the agreement. The Fund contends that the proceeds of the legal malpractice settlement are not subject to EBI's asserted lien. We agree that EBI does not possess a valid lien against the malpractice settlement proceeds, but we do so for reasons other than those advanced by the Fund.

As previously stated, the proceeds of a third party settlement are subject to an insurer's lien as paying agency. See ORS 656.593. However, this provision is contingent upon the insurer status as a paying agency on a compensable injury due to the negligence or wrong of the third person. We recently dealt with this requirement in Marvin C. Wright, 41 Van Natta 36 (1989). Claimant in Wright had been involved in an automobile accident resulting in injuries. Claimant filed workers' compensation claims with a number of employers. SAIF, on behalf of several noncomplying employers, denied compensability of the claims. Claimant subsequently filed a third party suit. While the claim was still in denied status, claimant settled the third party action. None of the proceeds of that settlement were distributed to SAIF.

Thereafter, SAIF's denial was set aside on Board review. SAIF, asserting entitlement to a share of the proceeds from the prior settlement, petitioned the Board for resolution of the dispute. Following review, we concluded that SAIF was not entitled to any portion of claimant's settlement. We noted that, at the time of the settlement, claimant's injury claim was in denied status. Because SAIF was not "paying benefits to the worker" at the time of the settlement, we found that SAIF was not a "paying agency" as defined by ORS 656.576.

Here, EBI was similarly not a paying agency with regard to a compensable claim at the time of the settlement agreement. First, EBI was not the insurer on the risk at the time of the June 23, 1983 automobile accident which gave rise to the third party suit. Rather, Fireman's Fund was the carrier on the risk at that time. Thus, any benefits which were paid by EBI were paid pursuant to the compensable April 15, 1983 injury rather than the June 23, 1983 automobile accident. Moreover, on September 19, 1985, EBI issued a denial of continued responsibility for claimant's low back condition on the basis that claimant had injured his low back in the June 23, 1983 automobile accident. As of the date of the settlement agreement, EBI's denial had become final by operation of law. Consequently, EBI is not a paying agency as defined by ORS 656.576.

Finally, a lien can only be enforceable against a third party recovery attributable to a compensable injury. See ORS 656.578; 656.593. Here, the injuries arising from claimant's June 23, 1983 automobile accident were never accepted by EBI. Indeed, EBI expressly denied claimant's shoulder and arm conditions in February 1984 and his low back condition in September 1985. Inasmuch as EBI never accepted claimant's injury claim arising from the June 23, 1983 automobile accident, either voluntarily or in compliance with a litigation order, the claim is not compensable and EBI is not entitled to a third party lien.

Accordingly, we hold that EBI's approval of the malpractice settlement was not required and that EBI is not entitled to a share of the settlement proceeds under the third party statutes.

IT IS SO ORDERED.

Board Member Ferris, specially concurring:

I agree that EBI Companies, the purported paying agency, is not entitled to a share of the malpractice settlement. In reaching this conclusion, I note that EBI's denial of responsibility had become final by operation of law at the time of the settlement. Therefore, claimant's recovery was not attributable to a compensable injury for which EBI was responsible.

I specifically do not agree with the reasoning expressed by the holding of Marvin C. Wright, 41 Van Natta 36 (1989). Wright holds that the critical time to determine whether a carrier is a "paying agency" as defined by ORS 656.576 is the date of the settlement. I disagree.

I submit that until the compensability issue has been finally resolved, the question of whether a carrier is a paying agency remains viable. Therefore, any proposed settlement of potential third party actions should either be held in abeyance or the proceeds placed in escrow pending the ultimate resolution of the compensability litigation.

As previously noted, EBI's denial had become final by operation of law at the time of the settlement. Since the compensability question had been finally determined at the time of the settlement, the Wright holding is not directly controlling. Consequently, although I disagree with the principle enunciated in the Wright case, I concur with the conclusion that EBI is not a paying agency.

CHARLENE TOOLE, Claimant
Steven Hendricks, Claimant's Attorney
Dixon, Nicholls & Friedman, Attorneys
Schwabe, et al., Defense Attorneys
Martin, Bischoff, et al., Attorneys
Cooney, Moscato & Crew, Attorneys

WCB TP-89003
August 17, 1989
Third Party Distribution Order

A purported paying agency has petitioned the Board to resolve a dispute concerning a purported third-party settlement. See ORS 656.587; 656.593. The paying agency contends that the settlement between claimant and the Professional Liability Fund (the malpractice insurer for claimant's attorney in the third party lawsuit) is void for want of prior approval by the paying agency. The Professional Liability Fund ("the Fund"), on behalf of claimant, argues that the Board lacks jurisdiction to address the issue. Alternatively, the Fund asserts that the paying agency's lien does not extend to the settlement proceeds.

We conclude that we may properly exercise jurisdiction over this matter and that the paying agency's lien attaches to the proceeds of the settlement in question. Moreover, the settlement agreement is void because it was not made with the approval of the paying agency.

FINDINGS OF FACT

On January 24, 1984, while performing her employment duties as a home health care nurse, claimant was involved in a motor vehicle accident. As a result of this accident, claimant sustained injuries involving her neck and back. The claim was accepted by the paying agency.

On February 17, 1984, the paying agency notified the driver of the other vehicle that it was providing workers' compensation benefits to claimant and informed the driver of its statutory lien against any subsequent settlement which might result from the accident.

On February 28, 1984, claimant executed an election form stating that she elected to seek recovery against the third party or parties who caused the accident. Claimant subsequently commenced a third party action against the owner and the operator of the other vehicle.

Claimant's third party suit was tried in Multnomah County Circuit Court on February 4, 1986. The jury trial resulted in a judgment in favor of the third party defendants. Claimant sought review with the Court of Appeals. On June 25, 1986, claimant's appeal was dismissed on the grounds that the notice of appeal was not timely filed.

Claimant asserted a claim against her attorney for alleged negligence in the handling of her third party claim. Claimant's attorney was insured for malpractice through the Fund. The paying agency subsequently notified the attorney who represented claimant in her legal malpractice claim that the paying agency asserted a lien as to any recoveries in the legal malpractice matter.

On December 23, 1986, the Fund notified the paying agency that the malpractice action had been settled by the parties for the sum of $7,200, less costs of $1,500 incurred by claimant's

former attorney in the third party action, for a net settlement of $5,700. The settlement agreement expressly noted that the paying agency asserted a lien in the amount of $7,683.79. The agreement further provided that claimant's attorney in the third party matter would "defend, indemnify and hold [claimant] harmless from any claims, actions, lawsuits, or damages claimed by [the paying agency] on its claimed lien against the settlement proceeds."

On January 14, 1987, the paying agency notified the Fund that either: (1) the Fund should satisfy the paying agency's lien, or (2) the matter should be presented to the Board for resolution of the dispute. When the Fund failed to respond to this letter, the paying agency petitioned the Board for relief pursuant to ORS 656.576 to 656.595.

FINDINGS OF FACT

Claimant's malpractice claim against her former attorney was ancillary to her third party action.

CONCLUSIONS OF LAW AND OPINION

If a worker receives a compensable injury due to the negligence or wrong of a third person not in the same employ, the worker shall elect whether to recover damages from such third person. ORS 656.578. If the worker elects to pursue a third party action, and if the worker settles the third party claim, 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(1); Estate of Troy Vance v. Williams, 84 Or App 616, 619-20 (1987). Any settlement by the worker is void unless made with the written approval of the paying agency or, in the event of a dispute between the parties, by order of the Board. ORS 656.587.

The paying agency argues that claimant's settlement with the Fund is void because it was not made pursuant to either written approval from the agency or Board order. In response, the Fund contends that the paying agency's statutory lien does not extend to a recovery against an attorney, or the attorney's insurer, for damages resulting from alleged malpractice arising out of the third party action. The Fund cites several cases from other jurisdictions which support, to one degree or another, this proposition. We conclude, however, that current Oregon law is contrary to the Fund's contention.

We conclude that the Court of Appeals' decision in Shipley v. SAIF, 79 Or app 149, rev den 301 Or 338 (1986), is controlling. In Shipley claimant recovered a judgment for the negligence of a third party defendant. However, the insurer for the third party defendant refused to pay the judgment. Claimant then filed an action against the insurer on the policy. A jury found in favor of claimant and awarded him the amount of the original judgment plus interest.

SAIF, the paying agency on the underlying claim, asserted its statutory lien on the recovery. claimant objected to SAIF's lien. Claimant argued that the lien can only arise out of an action for the "negligence or wrong of a third person" and not out of an action by the beneficiary of an insurance contract. We

rejected claimant's argument and held that SAIF had a valid lien. Claimant sought judicial review.

On review, the court affirmed. The court reasoned as follows (79 Or App at 152):

> "Plaintiff elected to seek recovery against the third party, and he successfully obtained an award of damages for the negligently inflicted injury. Only because the third party's insurer denied coverage did plaintiff have to initiate an action to recover the amount of the judgment. That action was ancillary to the action against the insured, because, without the judgment against the insured, no cause of action against the insurer could have existed. Plaintiff's ultimate recovery of damages arose out of the negligent conduct of the third party, and the proceeds are properly subject to a lien by SAIF."

Similarly here, the settlement arose out of claimant's third party action. In addition, the settlement proceeds resulted from a policy of insurance, just as the judgment proceeds were paid pursuant to an insurance policy in Shipley.

The Fund attempts to distinguish Shipley on the basis that the ultimate recovery to the paying agency in Shipley arose out of the third party's negligence that caused the actual compensable injury. Here, there has not been a finding that the third party defendants were, in fact, negligent. The Fund also contends that the alleged malpractice of claimant's attorney caused no "compensable injury" to claimant and, therefore, that no recovery under the statute is authorized. By use of the term "compensable injury" the Fund apparently refers to an injury resulting in a claim which is compensable under the workers' compensation statutes. See ORS 656.578.

However, we conclude that the Fund misreads both the statute and the court's opinion in Shipley. The fact that claimant did not recover a judgment against the third party defendants is not dispositive under the statute. It is frequently the case that settlements of third party claims do not involve admissions of liability. And yet, there can be no doubt that settlement of a third party action without an admission of liability is, nonetheless, subject to a paying agency's lien.

Nor does the fact that claimant's attorney's conduct did not result in a compensable injury defeat the paying agency's lien. To the contrary, in Shipley the insurer's conduct did not result in a compensable injury to claimant. Rather, the determinative factor in Shipley was that the ultimate recovery to claimant evolved out of claimant's third party claim. The same is true here.

The Fund also argues that the paying agency is not entitled to a share of the settlement proceeds because no "privity" existed between the paying agency and claimant's attorney. However, the paying agency's lien is purely statutory. It is established by the provisions of ORS 656.576 through 656.595 and does not depend upon contract or tort notions.

Therefore, we conclude that the paying agency's lien extends to the malpractice settlement entered into between claimant and the Fund. Consequently, paying agency approval of the settlement agreement is required by statute. ORS 656.587. Because the paying agency was not allowed an opportunity to object to the settlement agreement, the argeement is void.

IT IS SO ORDERED.

PATRICK L. BUCHANAN, Claimant
Richardson, et al., Claimant's Attorneys
SAIF Corp Legal, Defense Attorney

Own Motion 86-0278M
August 22, 1989
Own Motion Order of Remand

The SAIF Corporation has requested reconsideration of the Board's Own Motion Determination on Reconsideration, issued November 18, 1987. In that order, the Board closed claimant's own motion claim with an award of permanent and total disability. SAIF contends that claimant is not permanently and totally disabled. We disagree and adhere to our November 18, 1987 order, as supplemented herein.

FINDINGS OF FACT

Claimant sustained a compensable injury to his low back while working as a mechanic in 1970. He has undergone six spinal surgeries at the L4-5 and L5-S1 levels. His claim was last reopened by Board Own Motion Order, issued July 2, 1986, with temporary total disability compensation commencing September 20, 1985.

As a result of his injury and multiple surgeries, claimant currently experiences marked loss of lumbar flexion and extension. In addition, he is never totally free of pain except when he is in a reclining position. He is also subject to flare-ups of severe, disabling low back pain associated with standing, walking or sitting for even brief periods of time. During these flare-ups, he relieves his pain by reclining.

Claimant has an 11th grade education and is no longer able to work as a mechanic. Following his injury, he completed retraining in cosmetology and began working in that field in 1971. He currently owns a beauty school with his wife. He has not actively participated in this business or performed any other work since he experienced a severe flare-up of low back pain in July 1985.

The Board reopened the claim under its own motion jurisdiction with temporary disability commencing September 20, 1985.

FINDINGS OF ULTIMATE FACT

Claimant possesses the knowledge and skills to operate a beauty school and work as a cosmetology instructor or a cosmetologist. However, his symptomatic flare-ups would prevent him from participating in the operation of his cosmetology school on a regular and reliable basis, and he could not operate that business without the support of his wife. Furthermore, claimant would not be able to retain suitable, gainful employment in a normal, competitive market.

CONCLUSIONS OF LAW AND OPINION

In order to demonstrate that he is permanently and totally

disabled, a claimant must prove that he cannot regularly perform work at a gainful and suitable occupation. ORS 656.206(1)(a). A claimant is entitled to an award of permanent and total disability if he is unable to sell his services on a regular basis in a hypothetically normal labor market. Wilson v. Weyerhaeuser, 30 Or App 403, 409 (1977). A claimant who is unemployable except in sheltered employment carefully tailored to his physical needs is permanently and totally disable. Harmon v. SAIF, 71 Or App 724 (1985).

Here, SAIF contends that suitable, gainful employment is available to claimant within his own cosmetology business. In support of its position, SAIF relies on the opinion of treating neurologist Smith and claimant's vocational counselor. In July 1987, Dr. Smith reported that claimant's physical impairment was in the range of severe, and that he was limited to sedentary or very light activity. In a later report issued in September 1987, Dr. Smith opined that claimant "is capable of doing instructing and sales associated with beauty school work supplemented with clerical duties of bookkeeping." Based on Dr. Smith's opinion, claimant's vocational instructor determined that regular work within claimant's limitations was available in his own business.

There are a number of weaknesses in SAIF's argument. First, its position ignores the opinion of Dr. Fagan, claimant's long-time treating orthopedic surgeon. Dr. Fagan opined that claimant was permanently and totally disabled in April 1986, and again in August 1987. Dr. Fagan's opinion is entitled to considerable weight, as he has been involved in claimant's treatment since 1975.

Second, we note that Dr. Smith did not opine that claimant could perform the sedentary activities associated with his cosmetology business on a regular basis. See ORS 656.206(1)(a). In fact, portions of Dr. Smith's July 1987 report suggest otherwise. In that report, Dr. Smith noted that claimant would be able to dictate his own hours and would be supported by his wife and others who were actively working in the business. Dr. Smith further noted that claimant should be capable of "adapting his physical status to this occupation to a greater or lesser degree." These comments clearly suggest a "sheltered" working situation, rather than a normal labor market. See Harmon v. SAIF, supra; Wilson v. Weyerhaeuser, supra.

Finally, SAIF's argument does not adequately consider the physical limitations imposed by claimant's disabling pain. Claimant has repeatedly contended that his severe, symptomatic flare-ups would prevent him from performing even sedentary duties on a regular and reliable basis. There is nothing in the record to suggest that claimant exaggerates the amount of pain he experiences or the disabling effects of that pain. To the contrary, claimant's vocational counselor reported that "both [claimant and his wife] appear to be very sincere and very earnest in their efforts to attempt to identify potential work activity . . .". Claimant's credibility is further bolstered by his active participation in retraining activities and his return to the work force following his first four surgeries.

For these reasons, we are not persuaded by SAIF's argument, and we conclude that suitable, gainful employment is not available to claimant within his own cosmetology business. Furthermore, we find that claimant is not capable of obtaining and retaining suitable, gainful employment in a normal labor market. We, therefore, conclude

that claimant is entitled to an award of permanent and total disability.

ORDER

The Board adheres to and republishes our former order, issued November 18, 1987, as supplemented herein.

BARBARA A. JACOBS, Claimant
Glen Lasken, Claimant's Attorney
Craig Staples, Defense Attorney

WCB 87-06977
August 22, 1989
Order on Review

Reviewed by Board Members Ferris and Crider.

The self-insured employer requests review of Referee Schultz's order which set aside its denial of claimant's claim for right carpal tunnel syndrome. On review, the sole issue is compensability. We affirm.

FINDINGS OF FACT

Claimant is employed as an operating room nurse. On September 15, 1986, she was carrying, in her right hand, a pair of heavy, metal operating stirrups down a hallway towards the Operating Room when the stirrups twisted in her hand. She felt right hand pain immediately and, after adjusting her grip on the stirrups, she proceeded to the Operating Room. Shortly thereafter, she was adjusting the Operating Room fracture table, which required her to hang from an overhead beam in order to pull down a hydraulic lift mechanism, when she experienced numbness and tingling in her right arm.

Claimant sought treatment at the Emergency Room of her employer and was referred to Dr. Podemski, neurologist, to rule out the possiblity of thoracic outlet syndrome. Dr. Podemski assessed claimant's condition as "suspect right carpal tunnel syndrome." He prescribed anti-inflammatories and a wrist splint which claimant wore night and day for four weeks. Claimant filed a claim with the employer for right carpal tunnel syndrome, but did not miss work. During this time, she often worked shifts that were in excess of eleven hours.

Claimant saw Dr. Podemski again in October 1986. At that time, she reported that she continued to have tingling and discomfort in her right hand and had recently experienced occasional numbness in her left hand. Dr. Podemski performed repeat nerve stimulation studies and, after comparing those studies with the initial studies of September 1986, advised claimant that she needed to decide whether or not to have a carpal tunnel release.

Claimant was then referred to Dr. Nye who reported in December 1986 that clinical tests were positive on the right side and diagnosed right carpal tunnel syndrome.

In February 1987, Dr. Button, orthopedist, performed an independent medical examination. Dr. Button diagnosed bilateral carpal tunnel syndrome, more severe on the right. Dr. Button further noted that claimant had a positive family history for carpal tunnel syndrome and a possibility that she was predisposed to the condition because of a mild, now resolved, case of hypothyroidism.

In March 1987, the employer denied claimant's claim for

bilateral carpal tunnel syndrome. However, claimant had made no claim for injury to her left arm.

Prior to September 15, 1986, claimant had not experienced any carpal tunnel-related symptoms or other problems with her right wrist. She underwent a successful right trigger finger release approximately two years prior to the September 1986 incident. Claimant has not experienced problems with her hypothyroidism for the past few years.

FINDINGS OF ULTIMATE FACT

Claimant suffers from right carpal tunnel syndrome. The incident of September 15, 1986 was a material contributing factor to claimant's right carpal tunnel syndrome condition.

CONCLUSIONS OF LAW

The Referee concluded that the incident of September 15, 1986 was causally related to claimant's right carpal tunnel condition. We agree.

The issue of whether claimant's right carpal tunnel syndrome is related to the September 15, 1986 incident is a complex medical question. Thus, although claimant's testimony is probative, the resolution of the issue largely turns on an analysis of the medical evidence. Uris v. Compensation Department, 247 Or 420, 426 (1967); Kassahn v. Publishers Paper Co., 76 Or App 105, 109 (1985).

Dr. Podemski, claimant's treating physician, opined that "the type of physical activity that claimant was doing at work" significantly contributed to her carpal tunnel symptoms. Although Dr. Podemski does not specifically mention the September 15, 1986 incident, it is important to note that he obtained an accurate history of the incident when he began treating claimant. Given these circumstances, we find that Dr. Podemski was relating the onset of claimant's right carpal tunnel syndrome to the September 15, 1986 incident.

A contrary opinion is offered by Dr. Button, orthopedist, who performed an independent medical examination. Dr. Button opines that claimant's condition is idiopathic. He further diagnosed bilateral carpal tunnel syndrome and concluded that the September 15, 1986 incident did not contribute to claimant's condition because of its bilateral nature. Neither Dr. Podemski, nor Dr. Nye have diagnosed left carpal tunnel syndrome, and Dr. Button's report indicates no objective findings as to claimant's left wrist. We do not find that the claimant suffers from bilateral carpal tunnel syndrome.

Where the medical evidence is divided, we tend to give the greater weight to a treating physician's conclusion, absent persuasive reasons not to do so. Weiland v. SAIF, 64 Or App 810, 814 (1983). No such reasons appear here. Dr. Podemski had an accurate history of the September 15, 1986 incident and has had more of an opportunity to observe claimant's condition through his treatment of the condition. Further, Dr. Button's opinion is based upon a finding of left carpal tunnel syndrome, which was not diagnosed by the other physicians and is not supported by objective findings. Consequently, we are persuaded by Dr. Podemski's

conclusions and find that the September 15, 1986 incident was a material contributing cause of the right carpal tunnel syndrome condition.

ORDER

The Referee's order dated November 4, 1987 is affirmed. For services on Board review, claimant's attorney is awarded a reasonable assessed fee of $750, payable by the self-insured employer. A client-paid fee, payable from the self-insured employer to its counsel not to exceed $915, is approved.

CYNTHIA G. LAVELLE, Claimant
Lonergan & Lonergan, Claimant's Attorneys
Lindsay, Hart, et al., Defense Attorneys

WCB TP-89015 & TP-89021
August 22, 1989
Third Party Distribution Order

Claimant has petitioned the Board for resolution of a conflict concerning the "just and proper" distribution of proceeds from a third party settlement. See ORS 656.593(3). Specifically, the dispute concerns the paying agency's entitlement to a lien for anticipated future medical expenditures. ORS 656.593(1)(c). We conclude that the paying agency has not established that it is reasonably certain that it will incur such expenditures.

FINDINGS OF FACT

In June 1987 claimant sustained a compensable injury when she was struck by a vehicle operated by a third party. She sustained fractures and other injuries to her pelvis, sacroiliac joint, clavicle, and face. Following hospitalization and a period of convalescence, claimant returned to light duty in November 1987.

A March 27, 1989 Determination Order awarded 14 percent scheduled permanent disability for the right leg and 29 percent unscheduled permanent disability. That order has not been appealed and the parties have agreed that it will not be appealed.

Claimant, approximately 35 years of age, experiences residual symptoms attributable to the following compensable injuries: (1) a fracture of her right hemipelvis and disrupted sacroiliac joint; (2) a fractured clavicle; and (3) facial lacerations and sensory deficit in her face. Her right leg is one-half inch shorter than the left leg, prompting her to periodically walk with a slight limp.

It is conceivable that her sacroiliac joint may become more symptomatic and, if so, that surgery could be an option. However, additional treatment for her condition is neither expected nor recommended. Moreover, claimant does not intend to undergo further treatment unless it is recommended by her treating physician.

A light dermabrasion for a facial scar has also been mentioned. Yet, the scar's effect can also be remedied by makeup. Furthermore, claimant is satisfied with the cosmetic result and has no intention of undergoing the abrading procedure.

Claimant engaged legal counsel to explore the possibility of bringing suit against the third party. With the paying agency's approval, claimant and the third party have settled her cause of action. Following distribution of litigation costs, attorney fees, and claimant's statutory one-third share, a

dispute remains concerning the disbursal of the remaining balance of settlement proceeds.

As of June 2, 1989, the paying agency has expended $18,826.65 in time loss and medical expenses. It predicts that it will incur approximately $11,600 in future claim expenditures. These costs are comprised of expenses for fusion surgery, x-rays, hospitalization, dermabrasion, physical therapy, prescriptions, and mileage.

The record fails to establish that it is reasonably certain that the paying agency will incur future claim expenditures.

CONCLUSIONS OF LAW

After the deduction of attorney fees, litigation costs, and claimant's statutory 1/3 share, the paying agency shall be paid and retain the balance of the third party recovery to the extent that it is compensated for its expenditures for compensation, first aid or other medical, surgical or hospital service, and for the present value of its reasonably to be expected future expenditures for compensation and other costs of the worker's claim under ORS 656.001 to 656.794. See ORS 656.593(1)(c). Such other costs do not include any compensation which may become payable under ORS 656.273 or 656.278. id. The balance of the recovery shall be paid to the worker or beneficiaries. ORS 656.593(1)(d).

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. Donald P. Bond, 40 Van Natta 361, 480 (1988); Leonard Henderson, 40 Van Natta 31 (1988).

Here, the paying agency contends that it has established that future expenditures for claimant's medical services are "reasonably to be expected." See ORS 656.593(1)(c). We disagree.

Based on a review of x-rays, Dr. Wilson, claimant's treating orthopedist, has noted that claimant has a "fibrous union [in the sacroiliac joint] and there is potential for further degeneration on the future with limited aggravational activities." If sacroiliac fusion surgery was performed, Wilson foresees surgical and hospitalization expenses of approximately $9,000.

Dr. Hardiman, orthopedist, performed an independent medical examination. Hardiman could "imagine that [claimant] might become more symptomatic in the region of the sacroiliac joint", and, if so, that the joint could be "fused or arthodesced at any point in time." However, reasoning that additional treatment would not likely be beneficial, Dr. Hardiman did not recommend that further procedures be undertaken.

After reviewing Dr. Hardiman's report, Dr. Wilson had the following reply:

> "It is my opinion that there is no way to predict that the patient will require any

surgery and it is certainly not something that I would expect. We can only speculate that there is some potential for future problems but it is certainly not expected or necessary that these events will occur requiring further surgery with regard to her sacrum."

The aforementioned medical opinions suggest that additional treatment is neither recommended nor considered to be beneficial. At most, sacroiliac fusion surgery is a speculative option, predicated on the appearance of "future problems." Inasmuch as these "future problems" are neither expected nor necessary, we are not persuaded that it is reasonably certain that the paying agency will incur future expenditures concerning claimant's sacoiliac condition. Consequently, we conclude that the paying agency is not entitled to a lien for anticipated future expenditures for that condition. i.e., surgery, x-rays, hospitalization, physical therapy, prescriptions, and mileage.

Finally, the paying agency asserts that it is entitled to a lien for future claim expenditures for the dermabrasion of a facial scar. Again, we disagree.

The scar, located in the left supraorbital area of claimant's forehead, is approximately 3 by 4 centimeters in dimension. It is whiter than normal skin and is further enhanced by tanning. Dr. Frisch, dermatologist, mentioned that the scar "could be easily improved cosmetically with light dermabrasion." The charge for such a procedure would be $75.

Yet, Frisch also concluded that makeup "could easily" remedy the color problem and that, "[i]f nothing were done, a good cosmetic result was obtained." Finally, by means of affidavit, claimant states that she is "perfectly satisfied with the cosmetic result" which has been obtained and does not consider makeup necessary.

Considering Dr. Frisch's opinion, as well as claimant's satisfaction with her appearance, we consider a future dermabrasion to be unlikely. Thus, because we are not persuaded that it is reasonably certain that the paying agency will incur future expenditures concerning claimant's facial injuries, we conclude that the paying agency is not entitled to a lien for anticipated future expenditures for a dermabrasion.

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.

JOY J. BROOKSHIRE, Claimant
Peter O. Hansen, Claimant's Attorney

Own Motion 86-0689M
August 23, 1989
Own Motion Order

Claimant requests review of the SAIF Corporation's February 13, 1989, Notice of Closure, which terminated temporary disability benefits as of January 23, 1989. Claimant contends that she is entitled to additional benefits.

By questionnaire, claimant reported that she had

returned to regular work on January 23, 1989. Hence, SAIF's termination of temporary disability benefits as of that date was proper.

SAIF's closure of the claim was based on a report by Dr. Smith, claimant's treating neurosurgeon. In the report dated January 12, 1989, Smith projected that claimant would be medically stationary as of January 23, 1989. However, we are not persuaded by a projection of when claimant will become medically stationary in the future. See, e.g., Carol K. Matthews, 41 Van Natta 1032, 1034 (1989). Smith's report is particularly less persuasive, because it indicates that claimant has suffered a symptomatic "setback" from which she is currently recovering. The obvious inference is that further improvement in claimant's condition is expected. However, the record does not include a subsequent report confirming that claimant achieved medically stationary status as projected. Absent such evidence, we do not find that claimant was medically stationary at the time of claim closure. SAIF's February 13, 1989, Notice of Closure is set aside and claimant's claim is remanded to SAIF for further processing according to law. When appropriate, the claim shall be closed by SAIF pursuant to OAR 438-12-055. Claimant's attorney is awarded 25% of the additional compensation granted by this order, not to exceed $100 as a reasonable attorney's fee. Reimbursement from the Reopened Claims Reserve is authorized to the extent allowed under ORS 656.625 and OAR 436, Division 45.

IT IS SO ORDERED.

MICHAEL D. BRUNER, Claimant
Welch, et al., Claimant's Attorneys
Beers, et al., Defense Attorneys

Own Motion 88-0065M
August 23, 1989
Own Motion Order on Reconsideration

This matter involves two separate requests for own motion relief relating to claimant's March 10, 1980, industrial injury. First, claimant requests review of the insurer's November 9, 1988, Notice of Claim Closure, which terminated temporary disability benefits as of September 27, 1988. Claimant contends that closure of his claim was premature. Second, the insurer has submitted to the Board claimant's claim for an alleged worsening of his March 10, 1988, industrial injury. The insurer has accepted responsibility for claimant's right knee surgery, performed on February 15, 1989, and recommends that claimant's claim be reopened for the payment of temporary disability benefits commencing on the date of surgery. Claimant's aggravation rights have expired.

We first address the propriety of the insurer's claim closure. Claimant's accepted claim is for two related conditions, the original right knee injury and a low back condition sustained from a fall caused by the right knee giving way. In February, 1988, the Board exercised its own motion authority to reopen claimant's claim for low back surgery. On November 9, 1988, the insurer closed the claim based on Orthopaedic Consultants' independent medical examination (IME) report of September 27, 1988. In that report the Consultants declared claimant medically stationary despite his complaints of persistent swelling and other symptoms in his right knee. Significantly, there is no indication in the record that copies of the IME report were forwarded to claimant's treating physicians for their concurrence. Indeed, none of claimant's treating physicians had indicated that claimant was medically stationary.

On the contrary, the treating physicians' reports before and after the IME suggest that claimant never achieved medically stationary status after low back surgery. Dr. Eubanks, the treating chiropractor since 1984, reported in her chart note of June 30, 1988, that claimant complained of swelling and aching in the right leg. On July 14, 1988, Eubanks reported that claimant was having a "problem" with his right knee. On November 9, 1988, Dr. North, the treating orthopedist since 1980, reported continued complaints involving the right knee and found medial jointline tenderness along the knee. When conservative treatment yielded unsatisfactory results, North requested an MRI scan. The scan revealed a medial meniscus tear, prompting North to recommend surgery, which was performed on February 15, 1989. Given the continuity of claimant's right knee symptoms which ultimately required surgery, the Consultants' IME report alone is insufficient to support a finding that claimant was medically stationary on or after September 27, 1988.

The insurer maintains that its closure of the claim was proper, arguing that, because the claim was reopened for low back surgery, it should be closed when the low back condition is medically stationary, regardless of whether the right knee condition is stationary. We disagree. When a claim has been reopened for a worsening of any compensable condition, it may be closed only when all compensable conditions under the claim are medically stationary. See, e.g., Rogers v. Tri-Met, 75 Or App 470 (1985).

Here, we do not find that claimant was medically stationary at the time of claim closure. Therefore, the insurer's November 9, 1988, Notice of Closure is set aside as premature and the claim is remanded to the insurer for further processing according to law. The insurer shall pay claimant temporary disability benefits for the period commencing September 27, 1988, and continuing until claimant returns to his regular work at his regular wage or is medically stationary, whichever is earlier. The insurer may deduct temporary disability benefits previously paid for that period. Claimant's attorney is awarded 25% of the additional compensation granted by this order, not to exceed $500, as a reasonable attorney's fee. Reimbursement from the Reopened Claims Reserve is authorized to the extent allowed under ORS 656.625 and OAR 436, Division 45. When appropriate, the claim shall be closed by the insurer pursuant to OAR 438-12-055.

Following our review of this record, we are not persuaded that claimant became medically stationary prior to right knee surgery on February 15, 1989. Consequently, claimant's claim may not be closed prior to surgery, effectively mooting claimant's request for reopening of his claim as of the date of surgery.

IT IS SO ORDERED.

DOROTHY CARTER, Claimant
Peter O. Hansen, Claimant's Attorney

Own Motion 88-0476M
August 23, 1989
Own Motion Order

Claimant requests review of the self-insured employer's January 13, 1989, Notice of Claim Closure, which terminated temporary disability benefits as of September 12, 1988. The Notice indicates that claimant became medically stationary on October 6, 1988.

Dr. Rosenbaum, claimant's treating physician, declared claimant medically stationary as of October 6, 1988. The record includes no contrary evidence on that point. Hence, the employer's closure of the claim was proper.

The employer terminated temporary disability benefits based on claimant's release for regular work beginning September 12, 1988. However, a release for regular work alone does not terminate claimant's entitlement to temporary disability benefits. See Fazzolari v. United Beer Distributors, 91 Or App 592, 595-96, recon 93 Or App 103, rev den 307 Or 236 (1988). Moreover, the Board order which reopened this claim specifically directed that temporary disability benefits are to continue until claimant returns to her regular work at her regular wage or is medically stationary, whichever is earlier.

Here, the record shows that claimant actually returned to work on September 12, 1988. However, there is insufficient evidence to find that claimant returned to her regular duties prior to becoming medically stationary on October 6, 1988. Rather, the evidence indicates that claimant was on a modified-work schedule in late September, 1988. Absent persuasive evidence that claimant returned to regular work prior to her medically stationary date, claimant is entitled to additional temporary disability benefits through the medically stationary date. Accordingly, the employer shall pay claimant temporary disability benefits for the period from September 12, 1988, through October 6, 1988, less time worked. Claimant's attorney is awarded 25% of the additional compensation granted by this order, not to exceed $200, as a reasonable attorney's fee. Reimbursement from the Reopened Claims Reserve is authorized to the extent allowed under ORS 656.625 and OAR 436, Division 45.

IT IS SO ORDERED.

CAROLE J. KELLEMS, Claimant
Pozzi, et al., Claimant's Attorneys
Schwabe, et al., Defense Attorneys

WCB 87-06030
August 23, 1989
Order on Review

Reviewed by Board Members Crider and Ferris.

The self-insured employer requests review of those portions of Referee Tenenbaum's order that: (1) set aside the employer's partial denial to the extent that the denial denied medical benefits for the residuals of claimant's previously accepted low back condition; and (2) awarded claimant's attorney a fee for services rendered in clarifying the denial. Claimant cross-requests review of that portion of the order that upheld the employer's denial to the extent that the denial denied compensability of claimant's spinal stenosis and degenerative arthritic back conditions. The issues on review are compensability and attorney fees. We reverse in part and affirm in part.

The employer's brief also raises the issue that an exhibit below was admitted in violation of OAR 438-07-005(3)(b). The objection to this exhibit was withdrawn at hearing. Therefore, receipt of the exhibit cannot be the basis of complaint on review.

FINDINGS OF FACT

At hearing, claimant was 47 years old. She has been

employed by the same employer for nine years. She suffered a compensable low back strain in 1982. She was treated by Dr. Eubanks, D.O., for pain in the sacroiliac with osteopathic manipulations. He treated her for low back pain at various times through 1985. Her claim was closed in May, 1985, with no award of temporary or permanent disability.

In 1986, claimant's symptoms changed. On January 27, 1987, Dr. Eubanks requested a CT scan. This showed degenerative changes of the facet joints and foraminal stenosis at L4-5.

Dr. Bachhuber, orthopedist, opined in February 1987, that claimant had degenerative facet changes and would probably continue to have recurrent episodes of back pain. Dr. Bergquist examined claimant in February 1987, and diagnosed probable degenerative disc disease.

On April 6, 1987, the employer issued a denial letter which states in relevant part:

> "The medical information we now have states that your current need for medical treatment and your present condition is not materially related to your injury of 1982. Also, any present need for time loss is not related to your August 26, 1982 injury. Therefore, on behalf of [the employer] we must respectfully deny any and all responsibility for your present medical treatment and any present need for time loss as it did not arise out of or in the course and scope of your employment with [the employer]. Please note, this is a partial denial only and we will continue to consider payment of benefits for conditions directly related to your August 26, 1982 injury."

Thereafter, claimant requested a hearing concerning the employer's denial.

ULTIMATE FINDINGS OF FACT

The record does not establish that claimant's 1982 compensable injury is a material contributing cause of her degenerative arthritic and stenosis conditions.

The employer did not deny responsibility for conditions and treatment attributable to claimant's 1982 compensable injury.

CONCLUSIONS OF LAW AND OPINION

The Referee upheld the partial denial to the extent that it denied the compensability of claimant's stenosis and degenerative arthritis. We agree.

The only evidence supporting a causal relationship between the 1982 injury and claimant's stenosis and facet arthritis is Dr. Eubanks' "check-the-box" response to a letter from claimant's counsel. Inasmuch as we consider the reports authored by Drs. Bachhuber and Bergquist to be more complete and

better reasoned, we find them more persuasive. Accordingly, based on the aforementioned opinions, we find that claimant's 1982 compensable injury is not a material contributing cause of her stenosis and degenerative arthritis.

The Referee set aside the denial insofar as it purported to deny claimant's continuing rights to medical services arising from her compensable low back strain. See ORS 656.245. In addition, for her attorney's efforts in setting aside a portion of the denial, claimant was awarded a statutory attorney fee. Since we conclude that the employer did not deny claimant's continuing rights to benefits attributable to her compensable injury, we disagree.

A claimant can be entitled to a carrier-paid attorney fee for clarifying an inartfully drafted denial. See Karola Smith, 38 Van Natta 76 (1986), aff'd mem, Smith v. The Hartford, 83 Or App 275 (1987). However, we do not consider the employer's denial to be ambiguously worded. Rather, we find it to be both clear and precise: (1) the employer was denying responsibility for claimant's current medical treatment because his present condition was not attributable to her 1982 compensable injury; and (2) the employer would continue to provide benefits for conditions attributable to the 1982 compensable injury.

As previously discussed, we are persuaded that claimant's current need for medical treatment was related to her stenosis and degenerative arthritic low back conditions. Since these conditions are not attributable to her 1982 compensable injury, the employer's partial denial should be upheld in its entirety. Furthermore, because the employer continued to insure claimant's rights to benefits for conditions related to her compensable injury, no clarification of the denial was necessary. Accordingly, we reverse those portions of the Referee's order that set aside a portion of the employer's denial and awarded a carrier-paid attorney fee.

ORDER

The Referee's order dated November 13, 1987 is affirmed in part and reversed in part. The self-insured employer's denial is upheld in its entirety. The Referee's award of an attorney fee is reversed. A client-paid fee, payable from the employer to its counsel, not to exceed $2,481, is approved.

MITCHELL J. PORTELLA, Claimant
Coons & Cole, Claimant's Attorneys
David Force, Attorney
Robert Fraser, Defense Attorney

WCB 87-05852
August 23, 1989
Order on Review

Reviewed by Board Members Ferris and Crider.

Claimant requests review of Referee Brown's order that upheld the insurer's partial denial of his right knee condition. On review, the issue is compensability. We affirm.

FINDINGS OF FACT

Claimant compensably injured his low back in August, 1986. He suffered pain in his low right back which radiated into his right buttock and thigh. He was treated conservatively by Dr. Conwell. Claimant did not injure his right knee in this industrial accident.

As part of his vocational rehabilitation, claimant entered a work hardening program on December 16, 1986. He indicated on the evaluation form that he had suffered buckling of his right knee prior to entering the program. Claimant successfully completed the work hardening program and was discharged on January 21, 1987.

On March 19, 1987, claimant was examined by Dr. James, orthopedist. He denied any prior history of knee problems. A medial meniscus tear was diagnosed in his right knee and arthroscopic surgery was recommended.

ULTIMATE FINDING OF FACT

The evidence does not establish that claimant's compensable injury or activity in his work hardening program was a material contributing cause of his current right knee condition.

CONCLUSIONS OF LAW AND OPINION

Claimant testified that he injured his right knee while attempting a series of "squats" during his evaluation for a work hardening program. Dr. Conwell opined on August 3, 1987, that claimant had suffered a reinjury of his right knee during the work hardening program. Claimant argues that the preponderance of the evidence establishes that he compensably injured his knee during the work hardening program.

The insurer argues that the activities in the work hardening program did not result in any injury to claimant's right knee and that claimant has not proven by a preponderance that his injury is compensable.

The Referee found that claimant suffered an increase in pain in his right knee as a result of an activity during work hardening, but found claimant had not supplied medical evidence of causation and therefore had not sustained his burden of proof by a preponderance.

We consider causation in this case to be a complex medical question, requiring competent medical evidence. Kassahn v. Publishers Paper, 76 Or App 105 (1985). While claimant's lay testimony may be probative on this issue, we find claimant to be an unreliable historian and give little weight to his testimony. See Coastal Farm Supply v. Hultberg, 84 Or App 282 (1987).

Claimant testified that he did not injure his right knee in his compensable accident. He also testified that he had suffered right knee problems before entering the work hardening program. He testified that he hurt his knee on the first day of the program, during his evaluation. He later testified that the knee was injured at a later date. He informed Dr. James in March 1987, that he had no prior history of knee problems.

The physical therapist noted in his chart that claimant reported increased pain in his right knee on one occasion from doing his exercises. The physical therapist was aware of claimant's prior problems with his right knee. Claimant wore a brace on the knee during part of the program which he put on at home. Claimant testified that the brace was one his wife had acquired previously for her arm.

Claimant relies on Dr. Conwell's opinion that claimant hurt his knee in the work hardening program. We give little weight to this report because it is entirely based on the history given to Dr. Conwell by claimant. We also note that Dr. Conwell's report indicates a reinjury of the right knee, and not a new injury.

Claimant also relies on Dr. James' report of March 19, 1987, which diagnosed a tear in the medial meniscus of his right knee. Dr. James related this to claimant's exercise program during work hardening, but based this relationship entirely on the history given to him by claimant. A medical opinion, as to causation, is persuasive only to the extent that the history relied upon is accurate. Miller v. Granite Construction Co., 28 Or App 473, 476 (1977). We therefore give Dr. James' opinion little weight on the issue of causation.

After reviewing all the evidence, we can conclude only that claimant suffers a torn medial meniscus of the right knee. We are unable to conclude when this injury occurred. In order to prove that his condition is compensable, claimant must prove by a preponderance that his right knee condition was causally related to either his industrial injury or to his activities during work hardening. Claimant testified he did not injure the right knee in the industrial accident. The evidence does not establish that he injured his right knee during work hardening. Thus, we find that claimant has failed to prove a causal relationship to either and therefore find his right knee condition not compensable.

ORDER

The Referee's order dated October 13, 1987, is affirmed. A client-paid fee, not to exceed $1,073.50, is approved.

MARY J. SISK, Claimant
Kenneth D. Peterson, Claimant's Attorney
Meyers & Radler, Defense Attorney

WCB 85-03136
August 23, 1989
Order on Review

Reviewed by Board Members Crider and Ferris.

Claimant requests review of Referee T. Lavere Johnson's order that: (1) upheld the self-insured employer's denial of an aggravation claim for her right carpal tunnel syndrome; and (2) declined to admit a medical report into evidence. The issues on review are aggravation, evidence and, alternatively, remand. We affirm.

The employer has moved to strike a portion of claimant's reply brief, contending that it addresses matters outside the scope of the employer's respondent's brief. The motion is denied.

FINDINGS OF FACT

We adopt the "Findings of Fact" of the Referee with the addition of the following ultimate finding of fact. Claimant's 1981 compensable neck and upper back injury is not a material contributing cause of her right carpal tunnel syndrome, or its worsening.

CONCLUSIONS OF LAW

We adopt the "Conclusions of Law" of the Referee with the following comments concerning the motion to remand. Claimant alternatively requests remand to consider medical evidence which was excluded by the Referee. The exhibit in question was submitted to the Referee and to opposing counsel less than 10 days before hearing. It was thus late. Former OAR 438-07-005(3(b). The record shows that claimant was allowed a postponement of over one year to produce this evidence. Therefore, we agree with the Referee that no good cause was shown as to why this evidence should be admitted. Furthermore, we are neither persuaded that the record has been improperly, incompletely, or otherwise insufficiently developed nor that the evidence was unavailable with the exercise of due diligence prior to the hearing. See ORS 656.295(5); Bernard L Osburn, 37 Van Natta 1054 (1985), aff'd mem, 80 Or App 152 (1986).

ORDER

The Referee's order dated September 9, 1987, is affirmed. A client-paid fee, payable from the self-insured employer to its counsel, is approved, not to exceed $280.

JOHN L. SMITH, Claimant
Olson Law Firm, Claimant's Attorney
Gail Gage (SAIF), Defense Attorney
Roberts, et al., Defense Attorneys

WCB 87-09402
August 23, 1989
Order on Review

Reviewed by Board Members Ferris and Crider.

The SAIF Corporation requests review of Referee Huff's order that: (1) set aside its denial of claimant's aggravation claim for his current low back condition; and (2) upheld the denial of a "new injury" claim for the same condition issued by Fred Meyer, Inc. The issues on review are compensability and responsibility. We affirm.

FINDINGS OF FACT

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

Claimant's low back symptoms attributable to his compensable injury with SAIF worsened in the form of an April 1987 flare-up of symptoms. As a result of this flare-up, claimant was temporarily disabled for a period exceeding 14 days.

CONCLUSIONS OF LAW AND OPINION

We adopt the Referee's "Opinion" with the following supplementation.

To establish a compensable aggravation under ORS 656.273(1), claimant must prove a worsening of his condition and a causal relation between the worsening and a compensable injury or disease. Van Horn v. Jerry Jerzel, Inc., 66 Or App 457, 459, rev den 297 Or 82 (1984). An actual worsening of the compensable condition must be established. Perry v. SAIF, 307 Or 654 (1989); Ybarra v. Castle & Cooke, Inc., 94 Or App 746, clarified 96 Or App 665 (1989).

To prove a worsening, claimant must show a change in his condition since the last arrangement of compensation which entitles him to additional temporary or permanent disability compensation. Smith v. SAIF, 302 Or 396 (1986). If a worsening involves a symptomatic flareup, and if the prior award contemplated symptomatic flareups, then the fact finder must determine whether the flareup was greater than that contemplated at the time of the last arrangement of compensation. Gwynn v. SAIF, 304 Or 345, 352-53 (1987). However, if a worsening is established, and if, as a result of that worsening, claimant requires in-patient hospitalization or is off work for more than 14 days, then claimant has proven an aggravation regardless of what is contemplated by the prior award. Perry v. SAIF, supra; Gwynn v. SAIF, supra.

Here, claimant received 20 percent unscheduled permanent disability for a compensable low condition in August 1986, pursuant to a prior Referee's order. In April 1987, symptoms related to claimant's compensable low back condition worsened, resulting in temporary disability in excess of 14 days. Inasmuch as claimant's temporary disability resulted from an actual worsening of his compensable condition and since that disability exceeded 14 days, he has established an aggravation regardless of what was contemplated by his prior award. Perry v. SAIF, supra.

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

ORDER

The Referee's order dated October 26, 1987 is affirmed. A client-paid fee, payable from Fred Meyer, Inc. to its counsel, not to exceed $488, is approved.

TRAVIS BALDWIN, Claimant
Charles Duncan, Claimant's Attorney
E. Jay Perry, Defense Attorney
Beers, et al., Defense Attorneys

WCB 88-05580, 88-04843, 88-10216 & 88-10217
August 24, 1989

Claimant requested, and EBI Companies cross-requested, review of Referee Gruber's order that: (1) upheld Liberty Northwest Insurance Corporation's denial of claimant's "new injury" claim for his current low back condition; (2) upheld EBI's denial of claimant's aggravation claim for the same condition; (3) set aside EBI's denial of claimant's medical services claim for the same condition; and (4) declined to assess penalties and attorney fees for alleged unreasonable denials. Claimant and EBI have submitted a proposed "Disputed Claim Settlement," which is designed to resolve all issues raised or raisable between them in this matter, in lieu of the Referee's order.

Pursuant to the settlement, claimant agrees to withdraw his request for Board review insofar as it pertains to issues concerning EBI. In addition, EBI agrees to withdraw its

cross-request for review. We have approved the agreement, thereby fully and finally resolving the issues raised or raisable between claimant and EBI, in lieu of the Referee's order. Consequently, those issues will not be further addressed. In reaching this conclusion, we wish to emphasize that our approval of the agreement should not be interpreted as a "finding" that the parties' contentions are true or that this "finding" can be binding in a future proceeding.

We retain jurisdiction over the remaining issues present in this case pursuant to claimant's request for review. This order shall be interim, pending our review of the remaining issues on appeal. Following our review, this order shall be incorporated into our final order.

IT IS SO ORDERED.

DICK L. BARNETT, Claimant
Quintin Estell, Claimant's Attorney
Schwabe, et al., Defense Attorneys

WCB 85-16010
August 24, 1989
Order on Review

Reviewed by Board Members Crider and Ferris.

The insurer requests review of Referee Foster's order that: (1) set aside its "de facto" denial of claimant's aggravation claim for a right elbow condition; and (2) assessed an attorney fee for failing to timely accept or deny the claim. The issues on review are aggravation and attorney fees. We reverse that portion of the order that found claimant sustained an aggravation.

FINDINGS OF FACT

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

Claimant compensably injured his right elbow in 1981. He was treated conservatively by Dr. Blake, orthopedist, who noted degenerative changes in claimant's elbow.

Claimant received 5 percent scheduled permanent disability, later raised to 15 percent by a December 13, 1982 stipulation. At the time of this arrangement of compensation, it was anticipated that short of an elbow replacement, claimant's condition would not improve and he would continue to suffer some pain from the condition.

Claimant declined vocational rehabilitation and started a business on his property. This business failed, and in 1985 he went to work as a salesman and was working at the time of hearing. He has not been off work because of his elbow since the last arrangement of compensation.

Claimant filed an aggravation claim on July 17, 1985. The insurer did not deny or accept this claim for over two years.

ULTIMATE FINDING OF FACT

The record does not establish that claimant's 1981 compensable injury is a material contributing cause of his current right elbow condition.

CONCLUSIONS OF LAW AND OPINION

Penalty and attorney fee

We adopt the Referee's "Opinion" concerning this issue.

Aggravation

Finding that claimant's compensable condition had worsened since the last award of compensation, the Referee concluded that claimant's aggravation claim should be accepted. Inasmuch as we are unpersuaded that claimant's current right elbow condition is causally related to his compensable injury, we disagree.

Although lay testimony concerning causation is probative, it may not be persuasive when the claim involves a complex medical question. See Uris v. Compensation Department, 247 Or 420, 424 (1967); Kassahn v. Publishers Paper Co., 76 Or App 105, 109 (1985). Here, claimant and his wife testified that claimant's right elbow problems originated with the 1981 compensable injury and continued to worsen through the ensuing years. We consider their testimony to be probative. However, considering the complex nature of claimant's current right elbow condition and its relationship to his 1981 compensable injury, we place greater weight on the medical evidence.

Dr. Blake, claimant's treating physician, opined in 1981 that nothing short of an elbow replacement would completely relieve claimant's right elbow symptoms. At that time, he suspected a prior fracture and degenerative disease. His opinion then was that the industrial accident contributed to claimant's condition and that claimant had suffered permanent disability as a result of the accident. Following a 1985 examination, Dr. Blake continued to hold the same opinion.

In November 1986 Dr. Blake reported that claimant's current symptoms were related to his previous industrial injury and that there had been further deterioration in the elbow. Thereafter, Dr. Blake was deposed and indicated a complete change of mind. He is now of the opinion that claimant's 1981 injury healed within 4-6 months and that none of claimant's present condition is the result of his industrial injury. Considering this reversal of opinion, we are unable to conclude that claimant's treating physician supports a causal relationship between the compensable injury and claimant's current right elbow condition.

We likewise find Dr. Hardiman's opinion in support of a compensable relationship unpersuasive. Dr. Hardiman, orthopedist, performed an independent medical examination on January 29, 1987. Based on a history that claimant had fractured his elbow in the 1981 accident, Hardiman opined that claimant's present condition was caused by the 1981 injury. However, the record fails to establish that claimant had sustained on elbow fracture. Therefore, we give little weight to this opinion since it is based on an incorrect history. See Miller v. Granite Construction, 28 Or App 473 (1977).

Inasmuch as the medical and lay evidence fails to persuasively support a causal relationship between claimant's

current condition and his 1981 compensable injury, we conclude that claimant has not proven an aggravation in accordance with ORS 656.273(1).

ORDER

The Referee's order dated October 14, 1987, is reversed in part. The insurer's denial of an aggravation claim is reinstated and upheld. The Referee's attorney fee award of $1,000 for services concerning the aggravation issue is reversed. The remainder of the Referee's order is affirmed. A client-paid fee, payable from the insurer to its counsel, not to exceed $1,006.50, is approved.

DINISA J. DUNBAR, Claimant
Francesconi & Associates, Claimant's Attorneys
Schwabe, et al., Defense Attorneys

WCB 87-05242
August 24, 1989
Order on Review

Reviewed by Board Members Crider and Ferris.

Claimant requests review of Referee Houquet's order which upheld the insurer's partial denial of claimant's medical services claim for psychological treatment. On review, the sole issue is compensability. We affirm.

FINDINGS OF FACT

We adopt the Referee's "Findings of Fact" with the exception of the last four lines in that section of his order.

FINDINGS OF ULTIMATE FACT

Claimant's compensable injury is not a material contributing factor to her need for psychological treatment.

CONCLUSIONS OF LAW

At the outset, we note that although we affirm the Referee, our decision is based on different grounds. The Referee upheld the insurer's March 10, 1987 denial on the grounds that claimant did not appeal the April 8, 1986 denial. The Referee reasoned that claimant's claim was barred by the doctrine of res judicata. We find however, that the April 8, 1986 denial only denied that claimant had sustained an aggravation or worsening of her compensable back injury. By contrast, the March 10, 1987 denial denied that claimant's psychological treatment was related to her industrial injury. Accordingly, claimant is not precluded from challenging the latter denial. We now turn to the merits of the case.

Claimant bears the burden of proving by a preponderance of the evidence that an industrial injury materially contributed to her disability or need for medical treatment. Hutchenson v. Weyerhaeuser, 288 Or 51, 56 (1979); Milburn v. Weyerhaeuser Co., 88 Or App 375, 388 (1987). Accordingly, claimant must establish that the industrial injury of January 1984, materially contributed to her current need for psychological treatment.

Following our de novo review of the record, including the lay testimony, we find that a preponderance of the evidence does not establish that the January 1984 industrial injury materially contributed to claimant's need for psychological treatment.

Claimant's treating psychologist, Dr. Leska, conclusorily relates claimant's current condition to her industrial injury in two reports. However, the bulk of his reports speak to the benefits of such treatment and provide no analysis of the causal connection. Accordingly, we are not persuaded by Dr. Leska. Somers v. SAIF, 77 Or App 259 (1986).

By contrast, Dr. Colbach, psychologist, testified that claimant's January 1984 compensable injury did not contribute to her psychological condition and need for treatment. He based this conclusion on the fact that: (1) claimant had not suffered a significant injury; (2) she did not seek treatment for long periods of time; and (3) her complaints varied depending upon who was examining her. He further noted that secondary gain, in the form of money, attention, and love, was the more probable reason that claimant kept experiencing pain symptoms, not substantiated by objective findings. He concluded that claimant did not have any psychiatric impairment due to the industrial injury although she has a tendency to overfocus pain complaints.

We find Dr. Colbach's well-reasoned opinion to be persuasive. Somers, supra. Accordingly, claimant has not established that her industrial injury is a material contributing cause to her current pyschological condition and need for treatment.

ORDER

The Referee's order dated November 16, 1987 is affirmed. A client-paid fee, not to exceed $896, is approved.

DEBRA A. HATCH, Claimant
Vick & Gutzler, Claimant's Attorneys
Gary Wallmark (SAIF), Defense Attorney

WCB 86-13499
August 24, 1989
Order on Review

Reviewed by Board Members Crider and Ferris.

Claimant requests review of Referee Baker's order that upheld the SAIF Corporation's denial of her claim for a neck injury. Claimant contends that work activity on or about July 10, 1986 caused a torticollis, or wryneck condition. The issue is compensability. We affirm.

FINDINGS OF FACT

Claimant is a 35-year-old office worker. She was first examined by Dr. McIntosh, chiropractor on March 14, 1986. Claimant reported neck and back pain and stiffness, pain on neck motion, headache, and fatigue. On March 17, 1986, Dr. McIntosh commenced chiropractic treatment. Claimant underwent frequent chiropractic treatment from March 17, 1986 through June 23, 1986. No claim was made that claimant's condition or need for treatment was work related.

At the time of claimant's final treatment on June 23, 1986, she continued to report pain persisting on right cervical rotation.

Claimant returned to Dr. McIntosh on July 9, 1986, exhibiting guarded posture and limited cervical motion.

The following day, on July 10, 1986, claimant visited

her family physician, Dr. Peto, complaining of slight tenderness in the right side of her neck following holding a telephone with her chin. Dr. Peto diagnosed mild torticollis, or wryneck. He prescribed medication, range-of-motion exercises and reassurance.

Over the ensuing weekend, on July 13, 1986, claimant experienced an acute exacerbation of symptoms after taking a hot shower. She returned to Dr. McIntosh on Monday, July 14, and was provided with a soft cervical collar. She arrived at work late on the 14th, but she worked the remainder of the day.

On Tuesday, July 15, claimant returned to Dr. Peto for a followup. He noted cervical muscle spasm with very limited range of motion.

Claimant began twice daily treatments with Dr. McIntosh. Claimant also treated twice with a masseuse over the ensuing days.

Claimant did not work on Wednesday, July 16, and Friday, July 18, due to neck and shoulder pain.

On July 17, Dr. McIntosh prepared a return-to-work recommendation indicating a March 14, 1986 injury date.

Claimant had physical therapy on July 21 and July 23.

On July 28, claimant filed a claim with the employer. She indicated that the nature of her injury was an "over strain to [her] neck" with an injury date of July 14, 1986.

On July 29, 1986, Dr. McIntosh prepared a First Medical Report indicating that he had first treated claimant on July 14, 1986 for an injury dated July 10, 1986.

On August 4, 1986, claimant began treating with Dr. Pearson.

FINDINGS OF ULTIMATE FACT

Claimant experienced mild neck pain and stiffness on July 9, 1986. We are unable to find that those symptoms, or the subsequent exacerbation of those symptoms on July 13, are materially related to her work activities.

CONCLUSIONS OF LAW AND OPINION

Reliability

The Referee concluded that claimant's testimony was not reliable. We agree. Comparing claimant's testimony to other reliable evidence in the record, we conclude that claimant's testimony is sufficiently inconsistent to render it not reliable.

For example, claimant denied an acute exacerbation of symptoms at home on July 13, 1986. However, the physical therapist's report dated July 21 relates a history of sudden onset of neck pain following a hot shower on Sunday, July 13. Claimant has established no reason to discredit the therapist's report. Moreover, two co-employees credibly testified that claimant related to them a history of sudden onset following a shower on July 13.

Similarly, the Referee found that claimant attempted to greatly minimize the involvement of any neck symptoms between March 14, 1986 and June 23, 1986. Our review of Dr. McIntosh's chart notes for that period indicates that neck pain and stiffness were among claimant's primary complaints during that period. In addition, claimant's explanation that her neck complaints somehow evolved out of her shoulder complaints is nowhere supported in Dr. McIntosh's chart notes.

Furthermore, claimant was unable to recall telling either the physical therapist or her coworkers that she suffered from a neck abnormality which she had been told was related to her birth. However, the physical therapist's report notes this history, as does the testimony of claimant's coworkers. Claimant also denied any prior neck and shoulder symptoms to Dr. Pearson, despite receiving extensive treatment to those areas between March and July, 1986. Finally, claimant testified quite emphatically that her prior neck and shoulder problems were "completely gone" with "no complications" as of June 23, 1986. However, Dr. McIntosh's chart notes indicate persistent pain at that time.

Based upon these inconsistencies, we conclude that claimant's testimony is not reliable.

Compensability

On review, claimant argues that even if her testimony is not reliable, nevertheless other documentary evidence establishes a compensable work injury on or about July 10, 1986. Claimant relies in this regard upon the reports of Dr. Peto and Dr. McIntosh to the effect that, on or about July 10, she was experiencing painful cervical symptoms following cradling of the telephone between her chin and her shoulder for long periods of time at work while performing other activities.

Our review of the record persuades us that claimant did experience neck pain and stiffness on July 9, 1986. However, we are not persuaded that those symptoms are materially related to claimant's work activities on July 9, 1986.

With regard to causation, Dr. Peto opined:

> "This condition may occur spontaneously. Usually patients will awaken with discomfort in their neck and are not aware of any particular trauma or it may have been caused by a minor trauma such as [claimant] related."

At most, Dr. Peto's opinion supports a possibility that claimant's work activities resulted in her wryneck condition. However, claimant must prove more than just the possibility of a causal connection. Gormley v. SAIF, 52 Or App 1055 (1981).

Dr. Pearson opined that claimant's work activities did result in her condition. However, claimant apparently expressly denied to Dr. Pearson any history of prior neck problems. Because claimant had prior neck complaints between March and June, 1986, Dr. Pearson's opinion is based upon a fundamentally flawed history. Moreover, Dr. Pearson was apparently unaware of claimant's acute exacerbation of symptoms on July 13, 1986.

Consequently, his opinion is not persuasive. See Miller v. Granite Construction Co., 28 Or App 473, 476 (1977).

Dr. McIntosh also opined that claimant's work activities resulted in her neck condition. Dr. McIntosh hypothesized that claimant's work activities had resulted in a nerve lesion. Dr. Peto disputes Dr. McIntosh's theory on the basis of studies performed by Drs. Goe and Anderson which showed no evidence of nerve damage. We find his comments in this regard to be persuasive. Moreover, we are unable to accept Dr. McIntosh's opinion that claimant's post-July 9, 1986 condition is different than the condition he treated extensively between March and June, 1986. We note in this regard that, on his July 17, 1986 report, Dr. McIntosh indicated a March 14, 1986 injury date. It was only subsequently, and without explanation, that Dr. McIntosh changed his opinion to indicate a July 10, 1986 injury date.

Claimant cites Collins v. Hygenic Corp. of Oregon, 86 Or App 484 (1987), in support of her claim. In Collins, the court found that claimant had persuasively established that work exposure to chemicals had resulted in a respiratory condition. In Collins, claimant had experienced no previous respiratory ailments. By contrast, claimant here continued to experience neck symptoms two weeks prior to the alleged injurious exposure. Further, in Collins, the court noted an absence of other reasonable explanations for claimant's symptoms. Id. at 492. Here, Dr. Peto opined that a wryneck condition could appear spontaneously.

In sum, considering claimant's prior continuing symptoms, her acute off-work exacerbation on July 13, 1986, and her unreliability as a witness, we are not persuaded that her work activities were a material cause of her neck condition on and after July 9, 1986.

ORDER

The Referee's order dated July 6, 1987 is affirmed.

RICHARD R. INGALLS, Claimant
Pozzi, et al., Claimant's Attorneys
Alan Ludwick (SAIF), Defense Attorney

WCB 86-03202
August 24, 1989
Third Interim Order of Remand

On April 15, 1988, we abated our March 24, 1988 Second Interim Order of Remand, which had referred this matter to the Referee with instructions to reconvene a hearing. We had remanded because the hearing reporter had failed to provide a transcript of the parties' previous hearing. When the reporter provided a partial transcript and assured the Board that the remaining portion of the transcript would soon be forthcoming, we issued our April 15, 1988 abatement order.

Since our receipt of the partial transcript (which apparently encompasses the first day of the hearing), we have received nothing further from the hearing reporter. Despite repeated assurances that the remaining portion of the transcript would be forthcoming, the reporter continues to refuse to comply with his contractual obligations.

These circumstances lead us to conclude that the remainder of the hearing transcript is unobtainable. Furthermore, the parties have been unable to reach an accommodation concerning the events

recorded in the unobtainable portion of the transcript. Consequently, we hold that this case has been improperly, incompletely or insufficiently developed. ORS 656.295(5). Therefore, remand is appropriate. In reaching this conclusion, we have considered the parties' prior objections to remand. However, we continue to adhere to the reasoning expressed in our Second Interim Order of Remand.

Accordingly, this matter is remanded to the Hearings Division. Inasmuch as the prior Referee is no longer employed by the Board, the Presiding Referee is directed to assign this case to another Referee. The assigned Referee shall reconvene a hearing at a location the Presiding Referee considers to be appropriate.

At this hearing, the parties shall be entitled to present further evidence, either testimonial or documentary, concerning the issues that were addressed at the prior hearings. This evidence may pertain to claimant's current condition and other relevant circumstances, as each exists as of the date of the reconvened hearing. See Sherman V. Griffith, 40 Van Natta 1619 (1988). The parties shall also be permitted to refer to the testimony previously recorded in the partial transcript received by the Board.

We retain jurisdiction over this matter. Upon completion of the hearing, the assigned Referee 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, the assigned Referee shall provide an interim order on remand, discussing the effect, if any, the additional evidence has had upon the 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.

GEORGIANA A. MAY, Claimant
Peter O. Hansen, Claimant's Attorney
Bullard, Korshoj, et al., Defense Attorneys

WCB 86-15380
August 24, 1989
Order on Review

Reviewed by Board Members Crider and Ferris.

Claimant requests review of that portion of Referee St. Martin's order which affirmed the Director's order that found claimant was not entitled to a second vocational training plan. On review, the sole issue is entitlment to a second training plan. We affirm.

FINDINGS OF FACT

We adopt the Referee's findings of fact as set out in the fifth paragraph of the order with the following supplementation.

In March 1985, Dr. Pasquesi restricted claimant from the use of office machines which required frequent repetitive hand use.

In March 1987, Dr. Long restricted claimant from using typewriters, computer keyboards, or other office machinery which required frequent, repetitive hand use.

FINDINGS OF ULTIMATE FACT

Claimant's physical limitations are currently the same ones she had at the time of claim closure.

Claimant's employment as a real estate agent and secretary is "suitable employment."

CONCLUSIONS OF LAW

The Referee declined to modify the Director's decision that claimant was not entitled to a second vocational training plan. We agree.

ORS 656.283(2) provides that the Director's decision as to authorization of a vocational program may be modified only if the decision: (a) violates a statute or rule; (b) exceeds the statutory authority of the agency; (c) was made upon unlawful procedure; or (d) was characterized as an abuse of discretion or clearly unwarranted exercise of discretion.

Claimant first argues that the Director's order violated former OAR 436-120-120(7) which does not require further training, after the completion of one training plan, unless it is necessary: (1) due to a change in the worker's limitations; or (2) due to an inadequacy of the previous plan to prepare a worker for suitable employment.

Although claimant may now be experiencing an increase in her symptomalogy, we are not persuaded that her limitations have changed. Dr. Pasquesi's March 1985 report notes that claimant should avoid using office machines such as typewriters, computers, etc., which involve frequent and repetitive hand movement. He goes on to opine that claimant would best be fitted for some type of sales work rather than mechanical work in an office. In March 1987, Dr. Long reported that claimant should be restricted from continuous or repetetive hand activities such as typing, computer terminal work, or handwriting. After comparing the two descriptions of claimant's physical restrictions, we are not persuaded that her limitations have changed.

Claimant next argues that the Director's order violated the latter half of former OAR 436-120-120(7), as well as former OAR provisions 436-120-030(3) and 436-120-090(4). The focus of the argument surrounding these provisions, is that training and subsequent employment as a real estate agent is not "suitable employment" for claimant. Claimant's major contention is that she is not making a wage comparable to her preinjury wage, therefore, her job as a real estate agent is not "suitable employment."

Former OAR 436-120-005(7)(a) defines "suitable employment as:

> "employment of the kind which the worker has the necessary knowledge, skills and abilities; located where the worker customarily worked, or within commuting distance of either the worker's residence at the time of claim or current residence; and providing a wage as close as possible to the wage currently being paid for employment which is the regular employment of the worker."

We first note that providing a wage as close as possible to the preinjury wage is not the sole determining factor in deciding what is "suitable employment" for a worker. This is

relevant in the instance case in that the real estate training was provided in part due to claimant's aptitude and skills for such a job. Further, it was a occupational goal which claimant wanted to pursue.

In regard to implementing a vocational training plan designed to provide a wage as close as possible to the preinjury wage, it is important to note that it is not meant to be a guarantee, but rather that the occupational goal of the training plan has the potential to provide an approximation of the preinjury wage. Further, in this case, vocational testimony indicated that the majority of real estate agents, in the relevant region, earn from $15,000 to $40,000 per year or more dependent upon their own motivation. Given this, we are persuaded that the previous vocational training as a real estate agent constitutes adequate preparation for "suitable employment." See former OAR 436-120-005(7)(a).

Lastly, claimant argues that the Director abused his discretion by "injecting fault" into the workers' compensation system. This argument is apparently based on the Director's conclusion that claimant understood the risks of a commission based occupation before entering into the training program. We do not find this conclusion, however, to create an abuse of discretion of an otherwise proper order.

The Director's order shall not be modified. See ORS 656.283(2).

ORDER

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

JESUSA ORTIZ, Claimant
Steven C. Yates, Claimant's Attorney
Schwabe, et al., Defense Attorneys
Stoel, Rives, et al., Defense Attorneys

WCB 87-11503 & 86-15254
August 24, 1989
Order on Review

Reviewed by Board Members Ferris and Crider.

Claimant requests review of that portion of Referee Huff's order which awarded claimant's counsel a $1,350 attorney fee payable out of claimant's compensation. The attorney fee was awarded as a result of the Referee's finding that Liberty Northwest Insurance Corporation was responsible for claimant's cervical condition. Liberty Northwest cross-requests review, asserting that claimant is not entitled to an attorney fee. On review, claimant contends that the attorney fee should be paid in addition to, rather than out of, compensation. We agree and modify.

FINDINGS OF FACT

In September 1986, claimant filed a claim, for a cervical condition, with a former employer, a self-insured employer. In October 1986, the self-insured employer denied both compensability and responsibility for the claim. In November 1986, claimant requested a hearing on the self-insured employer's denial.

In August 1987, a claim was submitted for the same condition to Liberty Northwest, who insured a second employer. A

hearing scheduled for September 28, 1987 was postponed to allow Liberty Northwest 60 days in which to accept or deny the claim. Liberty Northwest verbally denied responsibility at hearing on November 4, 1987. The self-insured employer also conceded compensability at the November 4, 1987 hearing, which left responsiblity as the only issue. No order pursuant to ORS 656.307 was issued at the time of the hearing.

CONCLUSIONS OF LAW

The Referee found Liberty Northwest's insured responsible for claimant's cervical condition and awarded claimant's counsel $1,350, payable out of claimant's compensation. We disagree and conclude that the attorney fee should be insurer-paid.

A claimant's attorney is entitled to a carrier-paid attorney fee under ORS 656.386(1) if the claimant prevails finally in a hearing before a Referee in a "rejected case." A rejected case is a case in which the claimant's entitlment to receive compensation is at issue. Short v. SAIF, 305 Or 541, 545-46 (1988). If no order is issued pursuant to ORS 656.307, claimant's entitlement to compensation remains at risk at the time of hearing. Theresa L. Howard, 41 Van Natta 338 (1989).

In the instant case, no ".307" order had issued. Therefore, claimant's entitlement to compensation remained at risk until the time of hearing. Accordingly, claimant's counsel is entitled to a carrier-paid fee for services rendered prior to and at hearing. Ronald L. Warner, 40 Van Natta 1082, 1194 (1988).

Finally, after considering the factors enumerated in OAR 438-15-010(6), we agree with the Referee that $1,350 is a reasonable attorney fee for claimant's counsel's efforts.

ORDER

The Referee's order dated December 16, 1987 is modified in part and affirmed in part. In lieu of the $1,350 attorney fee awarded claimant's counsel out of compensation, claimant's attorney is awarded $1,350, to be paid by Liberty Northwest. If all or any portion of the attorney fee awarded by the Referee has already been paid pending review, Liberty Northwest is directed to pay an amount equal to the previously paid portion to claimant. The remainder of the Referee's order is affirmed.

SANDRA J. ROSELLE, Claimant
Bruce Smith, Claimant's Attorney
Joseph Robertson, Defense Attorney

WCB 87-09576 & 87-15243
August 24, 1989
Order on Review

Reviewed by Board Members Crider and Ferris.

The self-insured employer requests review of that portion of Referee Seymour's order which set aside its denial of claimant's neck and back injury claim. On review, the sole issue is compensability. We affirm.

FINDINGS OF FACT

On April 27, 1987, claimant jumped down about three or four feet from a belt and landed on her feet on a concrete floor. Shortly

after this incident, she experienced pain and stiffness in her neck and lower back. Claimant sought treatment from Dr. Moore, chiropractor. He diagnosed: "acute cervicothoracic strain/assoc. myofacitis & muscular spasms/assoc. segmental dysfunction complicated by C4-5 spondylosis; and, acute lumbosacral strain complicated by marked L4-5 disc degeneration."

In May 1987, claimant was examined by Dr. Bowles, osteopath. Dr. Bowles diagnosed lumbar and cervical strain. On May 22, 1987, the employer denied claimant's claim on the basis that it did not arise out of her employment.

In June 1987, claimant was examined by Dr. Schwarz, neurologist. He reported that claimant's neurological examination was normal outside of some limitation in voluntary movement. Following the results of the neurological examination, Dr. Bowles reported that claimant had moderate osteoarthritis of the lumbar spine and mild osteoarthritis of the cervical spine.

In July 1987, claimant was examined by Dr. Goodwin. He diagnosed chronic neck and low back pain. Dr. Goodwin reported that there was no x-ray finding to explain claimant's disability and concluded that the disability was muscular, associated with myositis and muscle spasm.

FINDINGS OF ULTIMATE FACT

The incident of April 27, 1987 is a material contributing cause of claimant's current disability and need for medical treatment.

CONCLUSIONS OF LAW

The Referee concluded that the incident of April 27, 1987 was causally related to claimant's current disability and need for medical treatment. We agree.

Claimant bears the burden of proving by a preponderance of the evidence that the April 27, 1987 incident is a material contributing cause to her disability or need for medical treatment. Hutcheson v. Weyerhaeuser, 288 Or 51, 56 (1979). Material contributing cause means a substantial cause, but not necessarily the sole cause or even the most significant cause. Van Blokland v. Oregon Health Sciences University, 87 Or App 694, 697-98 (1987).

In the instant case, following the April 27, 1987 incident, claimant experienced pain in her neck and lower back. She sought medical treatment the following day from Dr. Moore, who diagnosed an acute cervicothoracic strain and an acute lumbosacral strain. Dr. Moore opined that the April 1987 incident was sufficient to create the symptoms and findings he observed.

Dr. Goodwin reported that x-rays did not substantiate claimant's disability and opined that the disability was muscular in nature, associated with myositis and muscle spasm. Dr. Bowles opined that the only disease processes related to the April 1987 incident would be the possible lumbar strain and possibly a temporary exacerbation of her underlying osteoarthritis. Dr. Bowles had previously diagnosed claimant's condition as a lumbar and cervical strain.

Although there is disagreement as to the diagnosis of claimant's condition, all the medical evidence relates at least a

portion of claimant's neck and low back disability and need for medical treatment to the April 1987 incident. We note parenthetically that even if we found Dr. Bowles opinion to be the most persuasive, claimant's current disability would still be compensable as Dr. Bowles attributed the increase in symptoms to the April 1987 incident. See Donald L. Call, 39 Van Natta 672 (1987).

Accordingly, we conclude that claimant has established a material causal connection between the April 1987 incident and her neck and low back condition. We reach this conclusion regardless of whether claimant's symptoms stem from a lumbar and cervical strain and/or a temporary symptomatic excerbation of the underlying osteoarthritis. See Karen M. Partridge, 39 Van Natta 137 (1987).

ORDER

The Referee's order dated November 27, 1987, is affirmed. For services on Board review, claimant's counsel is awarded a reasonable assessed fee of $310, payable by the employer. A client-paid fee, not to exceed $1,297.50, is approved.

LORI L. AASTED, Claimant
Kirkpatrick & Zeitz, Claimant's Attorneys
Roberts, et al., Defense Attorneys

WCB 87-04889
August 31, 1989
Order on Review

Reviewed by Board Members Ferris and Crider.

The self-insured employer requests review of Referee Smith's order which set aside its partial denial of claimant's claim for chiropractic treatment in excess of two times per month for a low back injury. On review, the issue is reasonableness and necessity of chiropractic treatment. We reverse.

FINDINGS OF FACT

In 1983, claimant sustained a noncompensable injury to her neck and back in an automobile accident. Dr. Urban, chiropractor, diagnosed a cervical strain and provided treatment for this condition through 1985. In February 1985, claimant sustained a compensable injury to her low back when she slipped and fell. She sought treatment from Dr. Urban, who diagnosed a low back strain/sprain.

Dr. Urban released claimant for modified work in May 1985. Thereafter, he continued to treat claimant on a twice-a-week basis. Claimant was examined by Dr. Heusch, osteopath, in May 1985. Dr. Heusch diagnosed a probable lumbar strain and noted that the examination revealed minimal objective findings. In November 1985, claimant was examined by Dr. Langston, orthopedist. Dr. Langston diagnosed a lumbosacral musculoligamentous strain by history and functional overlay. He reported that claimant's current treatment was palliative and felt she had no impairment relative to the industrial injury.

In March 1986, Dr. Urban noted that claimant had poor recuperative powers, which were slowing down her recovery from the industrial injury. A Determination Order issued on March 20, 1986, awarding claimant temporary disability benefits only. Subsequently a stipulation granted claimant 10 percent unscheduled permanent disability.

Claimant continued treatment with Dr. Urban on a twice weekly basis. Claimant quit working for the employer in July 1985 when her husband was seriously injured in an accident. She provided attendant care for her husband and received payment for her services from her husband's carrier.

In February 1987, Dr. Urban reported that claimant had suffered an exacerbation. On February 19, 1987, the employer issued a denial of claimant's aggravation. It further denied any and all treatment rendered by Dr. Urban in January 1987 on the basis that his chartnotes indicated that he was treating areas not related to the industrial injury.

Beginning in April 1987 Dr. Urban treated claimant on a twice-monthly basis. In May 1987 the employer issued an addendum to its February 1987 denial, which denied all chiropractic treatment directed towards claimant's knees, elbows, shoulders, hips, feet, wrist and neck. The employer further denied any treatment, of the compensable low back, in excess of two times per month.

Claimant experienced a gradual temporary relief of her pain as a result of Dr. Urban's treatments. This relief extended from between two and four weeks.

FINDINGS OF ULTIMATE FACT

We are unable to find that chiropractic treatment, in excess of two times per month, is reasonable and necessary as a result of claimant's compensable low back injury.

CONCLUSIONS OF LAW

At the outset, the Referee's order directed the employer to pay for treatment for claimant's noncompensable neck condition. We find this to be in error, as the issue at hearing was treatment for claimant's compensable back injury. Accordingly, to the extent the Referee's order places responsibility on the employer for claimant's noncompensable neck condition, it is reversed. We now proceed to the merits.

The Referee concluded that all of Dr. Urban's treatment for claimant's low back was reasonable and necessary as a result of claimant's compensable injury. We disagree.

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).

Claimant's treating chiropractor, Dr. Urban, reported that claimant, at a minimum, needed ongoing palliative care in order to keep her condition in check. He further reported that claimant's recovery was being slowed by her poor recuperative powers and a series of unrelated illnesses and allergies.

Conversely, the Consultants opined that claimant was medically stationary and that further care was neither curative or palliative. The Consultants further opined that claimant would

get the same benefit from home exercises. Moreover, Dr. Abrams, who testified on behalf of the Consultants, opined that claimant may have a tendency to develop an emotional dependency on chiropractic treatment.

In conjunction with this, Dr. Langston opined that chiropractic treatment was only palliative, counterproductive and should be discontinued. He opined that claimant's complaints were not supported by objective findings and felt that she exhibited functional overlay, manifested by inconsistencies and interference.

Claimant testified that Dr. Urban's treatment loosened up muscles in her back and afforded her gradual relief from pain. She further testified that she gets relief from the chiropractic treatment that lasts from two to four weeks.

Under these circumstances, we conclude that claimant has not established that chiropractic treatments, in excess of two times per month, are reasonable or necessary. Although Dr. Urban opined that claimant needed continued care, his opinion does not explain why treatment in excess of the guidelines set forth in OAR 436-10-040(2) are reasonable and necessary. Further, claimant's credible testimony indicates that she obtains relief from pain for a period between two and four weeks. Accordingly, chiropractic treatment, in excess of two times per month, is neither reasonable nor necessary in this instance.

ORDER

The Referee's order dated November 25, 1987 is reversed. The self-insured employer's May 27, 1987 denial is reinstated and upheld. A client-paid fee, not to exceed $1,312.50, is approved.

JOSEPHINE H. ANDERSON, Claimant
Bischoff & Strooband, Claimant's Attorneys
Nancy Marque (SAIF), Defense Attorney
Roberts, et al., Defense Attorneys

WCB 87-05752 & 87-15505
August 31, 1989
Order on Review

Reviewed by Board Members Ferris and Crider.

Claimant requests review of those portions of Referee Paulus' order that: (1) upheld Globe Indemnity Company's "back-up" denial of claimant's low back and left leg injury claim; (2) found that Globe Indemnity's earlier denial was thereby rendered moot; and (3) found that claimant's challenge to a Determination Order was also moot as a result of her decision on the "back-up" denial issue. Claimant does not challenge the Referee's conclusion that Globe Indemnity's denial was permissible under Bauman v. SAIF, 295 Or 788 (1983). Rather, claimant contends that she has proven the compensability of her claim on the merits. We affirm.

ISSUES

1. Compensability of claimant's low back and left leg injury claim.

2. If compensable, then extent of permanent disability.

FINDINGS OF FACT

The Board adopts the Referee's Findings of Fact with the following supplementation.

Prior to her employment with Globe Indemnity's insured, claimant experienced left leg symptoms, including a tendency to drag her left leg.

FINDINGS OF ULTIMATE FACT

We are unable to find that claimant experienced an on-the-job incident which either worsened her underlying low back and left leg condition or materially contributed to increased symptoms either requiring treatment or resulting in disability.

CONCLUSIONS OF LAW AND OPINION

The Referee concluded that claimant was not credible and that, without her own credible testimony, she was unable to prove the occurence of a compensable on-the-job injury. We agree.

Claimant's lack of credibility is apparent at many points in the record. When applying for her job with Globe Indemnity's insured, claimant stated that she had never been injured. In fact, as set forth in the Referee's order, claimant had experienced a low back and left hip injury in 1971 that had continued to cause her difficulties through 1985 at least. Claimant also admitted at hearing that she had lied about her prior work history when completing her application.

In addition, claimant testified that, prior to the alleged incident, she had experienced no leg or hip symptoms. However, an August 1981 report from the Orthopaedic Consultant's indicates that claimant felt that 30 percent of her distress was in the left leg. Moreover, the Consultants reported in July 1987 that claimant left a job in Reno, Nevada in March 1986 due to pain in the low back and left leg, as well as numbness in the left leg. This is in contrast to claimant's testimony at hearing that she left the job in Reno because she wanted to return home and that she was not really experiencing any significant problems at the time.

Claimant also testified that she told a former co-employee of the purported on-the-job injury. The co-employee stated that claimant reported no injury to her. The Referee accepted the co-employee's testimony over that of claimant. To the extent the Referee's decision in this regard was based based upon the demeanor of the witnesses, we defer to that finding. See Humphrey v. SAIF, 58 Or App 360 (1982).

Due to claimant's lack of credibility, we are unable to rely upon the medical reports which, in turn, are necessarily reliant upon claimant's reported history. For example, Dr. Baker, orthopedic surgeon, examined claimant in February 1987. Based upon claimant's reported history and his findings, Dr. Baker reported that claimant's December 1986 work incident had resulted in an acute disc protrusion. However, claimant had denied "previous significant back problems" to Dr. Baker. Instead, she reported to the physician that she had experienced a "low grade back incident" in 1978. To the contrary, the record establishes

that claimant's prior back problems were indeed "significant." Further, claimant failed to inform Dr. Baker of the fact that her prior "low grade" back problems had also resulted in significant leg symptoms.

In sum, we conclude, as did the Referee, that claimant has failed to establish that a compensable injury occurred while she was employed by Globe Indemnity's insured.

ORDER

The Referee's order dated February 3, 1988 is affirmed. The Board approves a client-paid fee, payable from Globe Indemnity to its counsel, not to exceed $1,132.50.

DENIALLE BRADFORD, Claimant
Roger Wallingford, Claimant's Attorney
Cooney, et al., Defense Attorney

WCB 87-04405
August 31, 1989
Order on Review

Reviewed by Board Members Crider and Ferris.

Claimant requests review of Referee St. Martin's order that: (1) declined to grant permanent total disability; and (2) increased her unscheduled permanent disability award for a low back injury from 35 percent (112 degrees), as awarded by Determination Order, to 55 percent (176 degrees). We affirm.

ISSUE

Extent of claimant's unscheduled permanent disability, including permanent total disability.

FINDINGS OF FACT

Claimant, a food packager, compensably injured her low back when she slipped and fell at work on August 5, 1977. She was diagnosed with a lumbosacral strain and taken off work briefly. After a period of conservative treatment, her claim was closed by Determination Order on December 13, 1977, with no permanent disability award.

In April, 1978, claimant began treating with Dr. Berselli, an orthopedist, for severe low back pain. The following month, claimant's symptoms worsened to include radicular pain in the right leg. A myelogram revealed a herniated lumbar disc. When conservative treatment failed to yield improvement, claimant underwent a lumbar laminectomy and discectomy on October 18, 1979. Her claim was closed by Determination Order on June 20, 1980, with an award of 10 percent unscheduled permanent disability.

Claimant continued to experience periodic exacerbations of her low back condition with symptoms occasionally radiating to both legs. Additional Determination Orders were issued on February 24, 1981, March 25, 1982, and February 8, 1983, with no additional awards of permanent disability.

In September, 1984, claimant underwent decompressive lumbar laminectomy and spinal fusion of L4 through S1. Her claim was closed by Determination Order on May 13, 1986, increasing her award to 35 percent unscheduled permanent disability.

Claimant was referred for vocational assistance in 1982. Her vocational counselor recommended retraining for employment. However, because claimant had fourth-grade reading and writing skills, claimant first enrolled in adult basic education classes to upgrade those skills. Claimant was uncooperative with vocational assistance efforts. Claimant initially resisted any return-to-work plan for fear of losing her social security disability benefits. Later, she was resistant to working at an hourly wage significantly less than the $11.27 she had been earning with the employer. She also wanted to complete a GED program rather than pursue vocational training.

Finally, in October, 1986, a training plan with the vocational objective of general clerical was developed. Claimant progressed very well with clerical training. However, in January, 1987, claimant developed bilateral wrist pain, later diagnosed as bilateral wrist tenosynovitis. Dr. Berselli related the condition to the typing required in training, and restricted claimant from any further typing or computer entry. The training program was modified to meet those physical restrictions. Nevertheless, claimant declined to resume training, indicating that she is in constant pain and that she could live on her husband's income. Claimant's claim was subsequently redetermined by Determination Order on March 9, 1987, with no additional permanent disability award.

Subsequently, claimant's vocational counselor developed a training plan with the new vocational objective of general (Office) helper to exclude typing. Berselli released claimant for training. However, claimant refused to participate in further vocational assistance services. Vocational assistance was terminated as of June, 1987.

Claimant was 49 years of age at the time of hearing. She completed the tenth grade and has prior work experience as a nurse aide, kitchen helper, day care center teacher and a food packager. She has transferable skills to semi-skilled work. She has neither worked nor sought work since 1982. She receives social security benefits and a union pension. As a result of her compensable injury, claimant has various physical restrictions amounting to mildly moderate permanent impairment and is limited to light work.

FINDING OF ULTIMATE FACT

Claimant did not make reasonable efforts to obtain regular gainful employment after sustaining her compensable injury.

CONCLUSIONS OF LAW AND OPINION

Permanent Total Disability

To establish her entitlement to permanent total disability (PTD), claimant must prove that she is unable to perform any work at a gainful and suitable occupation. ORS 656.206(1)(a); Harris v. SAIF, 292 Or 683, 695 (1982). Dr. Berselli, claimant's treating physician, released claimant for light work. Because claimant is not totally incapacitated, she can prevail only by proving that she falls within the so-called "odd-lot" doctrine. Under that doctrine, an injured worker, capable of performing work of some kind, may still be permanently

and totally disabled due to a combination of her physical condition and certain nonmedical factors, such as age, education, work experience, adaptability to nonphysical labor, mental capacity and emotional conditions. Clark v. Boise Cascade Corp., 72 Or App 397, 399 (1985). Because claimant is physically capable of working, she is statutorily required to make reasonable efforts to find work, although she need not engage in job seeking activities that would be futile. ORS 656.206(3); Welch v. Bannister Pipeline, 70 Or App 699, 701 (1984), rev den 298 Or 470 (1985).

The vocational reports include numerous references to claimant's lack of motivation in the vocational rehabilitation process. Ultimately, claimant refused vocational retraining as an office helper, despite being released for retraining by her treating physician. Although claimant's potential for reemployment is limited by social and vocational factors, we are not persuaded that greater vocational efforts would have been futile. A labor market survey in June, 1987, revealed job possibilities within claimant's physical capabilities. Because claimant foreclosed the possibility of reemployment by refusing further vocational retraining, we find that claimant did not make reasonable efforts to obtain employment. Consequently, claimant is not entitled to PTD benefits. See id.

Permanent Partial Disability

The criterion for rating unscheduled permanent partial disability is the permanent loss of earning capacity due to the compensable injury. ORS 656.214(5). In determining the loss of earning capacity, we consider medical and lay evidence of physical impairment resulting from the compensable injury and all of the relevant social and vocational factors set forth in former OAR 436-30-380 et seq. We apply those rules as guidelines, not as restrictive mechanical formulas. Harwell v. Argonaut Insurance Co., 296 Or 505, 510 (1984); Fraijo v. Fred N. Bay News Co., 59 Or App 260, 269 (1982). Claimant's age, limited education, limited labor market potential, loss of residual function, and mildly moderate impairment reduce her earning capacity. Nevertheless, we conclude that the 55 percent unscheduled permanent disability award adequately compensates her for the low back injury.

ORDER

The Referee's order dated March 16, 1988, is affirmed. The Board approves a client-paid fee not to exceed $800.

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

WCB 85-16044, 85-15871 & 85-14936
August 31, 1989
Order on Review

Reviewed by Board Members Crider and Ferris.

Claimant requests review of those portions of Referee Howell's order that: (1) set aside Liberty Northwest Insurance Corporation's denial of claimant's "new injury" claim for a low back condition; (2) upheld the SAIF Corporation's denial of an aggravation claim for the same condition; and (3) awarded claimant's attorney $300 for services at hearing, to be paid by Liberty Northwest.

We affirm and adopt that portion of the Referee's order which pertained to the responsibility issue. We modify the Referee's attorney fee award.

We previously remanded this case to the Referee for reconsideration in light of any stipulation the insurers and claimant may have made concerning claimant's attorney's entitlement to a carrier-paid fee instead of a fee payable out of compensation. Charles T. Brence, 39 Van Natta 704 (1987). The Referee, on reconsideration, found that the parties had agreed that claimant's attorney was entitled to a carrier-paid fee and, relying upon Evans v. Rookard, Inc, 85 Or App 213 (1987), found that the parties' stipulation was binding. Accordingly, the Referee awarded claimant's attorney a carrier-paid fee of $300, in lieu of the $750 "out of compensation" fee previously awarded.

On de novo review, after considering the factors enumerated in OAR 438-15-010(6), we find that a carrier-paid fee of $750, payable by Liberty Northwest, is a reasonable attorney fee concerning claimant's attorney's efforts in this case. In reaching this conclusion, we note that Liberty Northwest raised no objection to the Referee's previously awarded $750 "out of compensation" fee nor has it responded to claimant's request that he be granted a $750 carrier-paid fee.

ORDER

The Referee's order dated August 19, 1986, as modified on remand April 27, 1988, is modified in part and affirmed in part. In lieu of the Referee's attorney fee award, claimant's attorney is awarded a reasonable attorney fee of $750, to be paid by Liberty Northwest. If claimant's attorney has already been paid all or a portion of the $750 "out of compensation" fee, Liberty Northwest is directed to pay all of the already paid portion of the $750 to claimant. A client-paid fee, payable from Liberty Northwest to its counsel, not to exceed $232.50, is approved. The remainder of the Referee's order is affirmed.

LISA S. BROWN, Claimant
John Hilts, Claimant's Attorney
Kevin Mannix, Defense Attorney

WCB TP-89024
August 31, 1989
Third Party Distribution

Claimant has petitioned the Board for resolution of a conflict concerning the "just and proper" distribution of proceeds from a third party settlement. See ORS 656.593(3). Specifically, the paying agency contends that claimant's attorney's receipt of one-third of the gross recovery would be inappropriate. We conclude that an attorney fee equal to one-third of the gross recovery would be just and proper.

FINDINGS OF FACT

In March 1988 claimant sustained injuries resulting from a motor vehicle accident involving a third party. Claimant's injury claim for neck, low back, and bilateral shoulder conditions was accepted.

Claimant engaged legal counsel to explore the possibility of bringing suit against the third party. She and her counsel entered into a contingent fee retainer agreement, which

provided that her counsel would receive 33-1/3 percent of the proceeds if settlement was reached five days before trial.

Claimant, through legal counsel, and the third party have agreed to settle the potential cause of action for $25,000. The paying agency does not challenge the settlement. However, it objects to claimant's counsel's retention of one-third of the settlement proceeds as an attorney fee.

As of July 12, 1989, the paying agency had expended $20,826.68 in actual claim costs. Inasmuch as the claim remains in open status, further claim expenses will continue to accrue.

ULTIMATE FINDINGS

Claimant's attorney's fee, which does not exceed 33-1/3 percent of the gross recovery obtained by claimant from the third party settlement, is just and proper.

CONCLUSIONS OF LAW

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

The statutory formula for distribution of a third party recovery obtained by judgment, ORS 656.593(1), is generally applicable to the distribution of a third party recovery obtained by settlement. Robert L. Cavil, 39 Van Natta 721 (1987). ORS 656.593(1) provides in exact detail how, and in what order, the proceeds of any damages shall be distributed.

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

Here, the paying agency challenges claimant's counsel's entitlement to an attorney fee equal to one-third of the third party settlement. Noting that the third party agreed to "settle for its policy limits" without requiring the filing of a civil action, the paying agency asserts that "the maximum one-third attorney fee distribution is inappropriate." We disagree.

As previously noted, we generally apply the statutory formula for distribution of a third party judgment, ORS 656.593(1), to the distribution of proceeds from a third party settlement. Robert L. Cavil, supra. We take such an approach to avoid making "equitable distributions on an ad hoc basis" and to permit the parties to generally know where they stand as they seek

to settle a third party action. See Marvin Thornton, 34 Van Natta 34 Van Natta 999, 1002 (1982). We find no persuasive reason to depart from that approach here.

In accordance with ORS 656.593(1)(a), litigation costs and attorney fees shall be initially disbursed. The attorney fees shall in no event exceed the advisory schedule of fees established by the Board. ORS 656.593(1)(a). The Board's advisory schedule of fees is set forth in OAR 438-15-095, which provides that, absent a finding of extraordinary circumstances, an attorney fee not to exceed 33-1/3 percent of the gross recovery obtained by the plaintiff in a third party action is authorized.

Here, claimant proposes to distribute one-third of the $25,000 settlement proceeds to her counsel as an attorney fee. Such a distribution is in accordance with the contingent fee retainer agreement, which provided for an attorney fee equal to one-third of the proceeds if the case was settled five days prior to trial. Moreover, the requested fee does not exceed the Board's advisory schedule of attorney fees in third party cases. See OAR 438-15-095. Consequently, we conclude that claimant's counsel is entitled to receive one-third of the $25,000 third party recovery.

The paying agency is advocating a position that is available to any party in a dispute involving the distribution of a third party recovery. i.e., it would be more equitable to order a distribution that results in its receipt of a larger portion of the third party settlement. We have consistently rejected such an argument, reasoning that, in the long run the results would be random, standardless, and, thus, inequitable. See John C. Adams, 40 Van Natta 1794 (1988), aff'd mem Liberty Northwest v. Adams, 97 Or App 587 (July 19, 1989). Therefore, we hold that a one-third distribution of the settlement proceeds to claimant's attorney is "just and proper."

The paying agency's actual claim costs currently total $20,826.68. Since these costs exceed the balance remaining after claimant's attorney's fee, litigation costs, and statutory one-third share are deducted from the settlement, we conclude that the paying agency is entitled to the remaining balance of settlement proceeds.

Finally, claimant also seeks penalties and attorney fees for the paying agency's conduct during the negotiation of the settlement. Inasmuch as we are unaware of any authority permitting us to make such an assessment, the request is denied. See Arlo W. Dunbar, 40 Van Natta 366 (1988).

Accordingly, claimant's attorney is directed to distribute the third party settlement proceeds in accordance with ORS 656.593(1)(a), (b), (c), and this order.

IT IS SO ORDERED.

MORGAN L. FOREST, Claimant
Merrill Schneider, Claimant's Attorney
Rankin, et al., Defense Attorneys

WCB 87-06664
August 31, 1989
Order on Review

Reviewed by Board Members Ferris and Crider.

The self-insured employer requests review of Referee Peterson's order that set aside its partial denials of claimant's right shoulder, neck and back condition. On review, the sole issue is compensability.

We affirm.

FINDINGS OF FACT AND ULTIMATE FACT

We adopt the Referee's findings of fact and ultimate fact, including the findings set forth in the "Opinion" section of the Referee's order.

We made the following additional findings of fact.

Claimant has a history of intermittent back, neck and shoulder pain. In October 1985, she sought treatment for a flare-up of left shoulder and middle and upper back pain. Those symptoms resolved, and claimant did not experience further problems until she was accosted by a bus passenger on February 3, 1987.

Claimant's left shoulder, neck and back symptoms significantly increased when she returned to work on February 21, 1987.

CONCLUSIONS OF LAW AND OPINION

We adopt the Referee's opinion subject to the following comment.

The Referee deferred to the opinion of Dr. Cannard, claimant's treating chiropractor. He opined that claimant's shoulder, neck and back conditions were related to her compensable injury in February 1987. In deferring to Dr. Cannard, the Referee noted that Drs. Button and Smucker did not render a contrary opinion on this issue, but merely concluded that claimant's shoulder, neck and back problems were unrelated to her left wrist and thumb condition. The employer challenges this interpretation of their opinions.

We agree with the Referee's determination that Dr. Button limited his opinion to the relationship between claimant's shoulder, neck and back problems and her left wrist and thumb condition. However, after concurring in Dr. Button's opinion, Dr. Smucker recommended that claimant's neck, shoulder and back condition be processed as a "new case, not related to her injury earlier." We interpret Dr. Smucker's recommendation as an opinion that these problems were not related to the February 1987 injury.

Nevertheless, Dr. Smucker's opinion is entitled to little weight because it is based on an incorrect understanding of claimant's symptomatic history. In his chart note of May 26, 1987, Dr. Smucker noted that claimant did not complain

of left shoulder and neck pain when he examined her shortly after her injury. However, Dr. Smucker's own chart notes of February 9, 1987 clearly document left shoulder and neck pain, dating back to February 4, 1987. Accordingly, we discount his opinion and conclude that the Referee properly deferred to the report of treating physician Cannard.

ORDER

The Referee's order dated January 19, 1988, is affirmed. Claimant's attorney is awarded an assessed fee of $500, payable by the self-insured employer. The Board approves a client-paid fee, not to exceed $705.

RODGER L. GAINES, Claimant
Quintin Estell, Claimant's Attorney
Richard Barber, Defense Attorney

WCB 87-13833
August 31, 1989
Order on Review

Reviewed by Board Members Ferris and Crider.

Claimant requests review of those portions of Referee McMurdo's order that: (1) found that his aggravation claim for his low back had not been prematurely closed; and (2) affirmed a Determination Order which did not award any additional permanent disability beyond the 15 percent (48 degrees) unscheduled permanent disability awarded by a prior Referee's order. On review, claimant argues that the Referee improperly denied his request to keep the record open pending continuation of a physician's deposition. Claimant asks that the matter be remanded for completion of the deposition. We decline to remand and affirm on the merits.

ISSUES

1. Remand.

2. Premature Closure.

3. Extent of Permanent Disability.

FINDINGS OF FACT

The Board adopts the Referee's factual findings found on pages one and two of his order, with the following supplementation.

Dr. Stanley first examined claimant on March 31, 1986. Dr. Stanley's last report took the form of a November 20, 1987 concurrence with a letter drafted by a SAIF employee. This letter was submitted as an exhibit on November 23, 1987. A copy was mailed to claimant's attorney on that date. Hearing was held on December 15, 1987. At the conclusion of the hearing, the record was kept open for the taking of Dr. Stanley's deposition testimony.

A post-hearing telephonic deposition of Dr. Stanley was convened on January 27, 1988. During the course of that deposition, claimant's attorney suggested that the deposition be reconvened in person at a later date so that claimant's attorney would have an opportunity to review Dr. Stanley's file. The insurer's attorney and Dr. Stanley agreed with the suggestion.

The Referee, by letter dated February 23, 1988, notified the parties that the record would be closed as of February 29,

1988, whether or not the deposition of Dr. Stanley had been completed at that time. The deposition was not completed prior to that date. The Referee issued his order in this matter on March 14, 1988.

As of March 11, 1987, no further material improvement in claimant's low back condition would reasonably be expected from medical treatment, or the passage of time.

As of the date of hearing, claimant was limited to medium work as a result of his low back condition. He was experiencing no radiating symptoms in his left leg and only occasional symptoms in his right leg. He was restricted from other than occasional bending, squatting and crawling.

CONCLUSIONS OF LAW AND OPINION

The Board adopts the Referee's opinion with the following comment regarding the remand issue.

Claimant contends that the Referee improperly closed the record in this case without allowing completion of Dr. Stanley's deposition. We do not agree. At the time of hearing, the Referee requested that Dr. Stanley's deposition be submitted within 30 days. In fact, Dr. Stanley's deposition was not held until approximately 45 days later. When that deposition was discontinued, the Referee allowed an additional month within which to reconvene the deposition. In sum, the Referee did not close the record until two-and-one-half months had transpired since the hearing. The record does not disclose any culpability on the part of the insurer with regard to the delay in completing Dr. Stanley's deposition. Moreover, Dr. Stanley is not an independent medical examiner chosen by the insurer; rather, he has treated claimant for an extended period of time. Under these circumstances, we conclude that the Referee's decision was appropriate to achieve substantial justice. See Kenneth J. Graves, 40 Van Natta 1170 (1988).

ORDER

The Referee's order dated March 14, 1988 is affirmed. The Board approves a client-paid fee, not to exceed $639.60.

SHIRLEY L. GIVENS, Claimant
Francesconi & Associates, Claimant's Attorneys
Randolph Harris (SAIF), Defense Attorney

WCB 84-11674
August 31, 1989
Order on Review

Reviewed by Board Members Ferris and Crider.

Claimant requests review of Referee Galloway's order that: (1) declined to grant permanent total disability; and (2) increased claimant's unscheduled permanent disability for a low back condition from 40 percent (128 degrees), as awarded by a prior Determination Order, to 65 percent (208 degrees). The issue is extent of permanent disability, including permanent total disability. We affirm.

FINDINGS OF FACT

Claimant, 46 years of age at hearing, injured her low back on March 26, 1980, while working in a restaurant as a cook.

The injury occurred when she abruptly twisted her body in order to avoid being struck by a dish tray carried by a busboy. She had previously suffered low back symptoms which culminated in surgery in 1974; thereafter, her symptoms largely resolved prior to the March 1980 injury.

Claimant began treating with Dr. Manley, orthopedic surgeon, for low back, upper back and right arm and leg pain. On August 12, 1980, Dr. Manley performed a laminectomy at L4-5 and a fusion from L5 to the sacrum. He released her to return to light work in November 1980.

Claimant subsequently worked as a cook at two separate employments for brief periods in 1981. She was dismissed from both of these jobs. She was dismissed from the first job because she was not working quickly enough as a result, in part, of the symptoms of her 1980 injury. She was dismissed from the second job for reasons unrelated to her physical problems.

Claimant attended the Northwest Pain Center from February 1984 through March 1984. She was released from the program with "very solid gains in almost all areas."

In May 1984, claimant began to receive vocational assistance. She continued to receive assistance until March 1987. During this time, she undertook two on-the-job training programs. The first training program commenced on July 1, 1985, and involved bookkeeping duties. She performed well at this job. However, she withdrew from this program in August 1985 because she felt she was not receiving adequate supervision. The second program commenced in early 1986. Claimant received on-the-job training as a bill collector. Claimant showed good aptitude for the necessary skills. However, she withdrew from the program in April 1986 due to increased back pain attributable to the 1-1/2 hour bus ride to her training site. Thereafter, Dr. Manley restricted claimant from commuting more than 1 to 2 miles for employment purposes.

During the time that claimant was involved in these on-the-job training programs, she was also attending a five-month academic training program in accounting and clerical work. Claimant performed very well during this training program, and was rated an excellent candidate for employment as an accounting clerk upon discharge in August 1986.

In September 1986, claimant and her roommate drove to northeast Washington where they were in the process of purchasing a parcel of property. While at the property, they camped in a tent for one week. Earlier in 1986, claimant drove to California due to a family illness.

Claimant underwent a one-day work tolerance screening on December 8, 1986. She had been recently back-packing prior to her participation in this work tolerance screening.

On March 20, 1987, claimant withdrew from further vocational assistance, citing her intention to relocate to the property in northeast Washington that she and her roommate were purchasing.

Claimant is five feet, seven inches tall and weighs well in excess of 200 pounds. She has numerous health problems which

preexisted her 1980 injury including: chronic bronchitis, chronic staph infections, and eyesight problems primarily involving her left eye. None of these conditions were disabling at the time of her compensable 1980 injury. Nor were any of these conditions worsened by the injury. Since her injury, she has developed emphysema. This condition was not caused or worsened by her compensable injury.

Claimant has a tenth grade education. She has also obtained a GED. Her prior work experience is confined almost entirely to the restaurant/tavern business. She has worked as a cook, waitress, bartender, and assistant restaurant manager. She also worked as a retail sales clerk from 1977 to the spring of 1979, including a three-month stint as a store manager. As a result of her vocational training and instruction, claimant has acquired bookkeeping, accounting and other office skills.

Claimant experiences constant low back pain which extends into her hips. She also experiences aching which extends down the right leg to the mid-calf and is present most of the time. She experiences some symptoms in her left leg to the knee. Sneezing or coughing causes an acute exacerbation of symptoms. Claimant does her own cooking and washes her own dishes. She does her own shopping. She takes three Extra-Strength Tylenol tablets about every four hours. Her sleep is interrupted due to pain.

Claimant is capable of sitting, standing or walking one hour consecutively. She can stand for a total of two hours in an eight-hour workday. She can sit or walk for a total of four hours each during an eight-hour workday. She can frequently lift up to 10 pounds and occasionally lift up to 20 pounds. Her physical impairment resulting from the 1980 injury is in the moderate range.

As a result of her compensable injury, claimant is no longer able to perform any of her prior employments. However, as a result of her vocational training and educational activities, she is employable in bookkeeping and other sedentary and modified light positions.

Claimant experiences marked functional overlay which is volitional in nature.

CONCLUSIONS OF LAW AND OPINION

Permanent Total Disability

To prove entitlement to permanent total disability, claimant must establish that she is unable to regularly perform work at a gainful and suitable occupation. ORS 656.206(1)(a); Wilson v. Weyerhaeuser, 30 Or App 403 (1977). Claimant concedes that she is not totally incapacitated on a physical or medical basis alone. Instead, claimant contends that she falls within the so-called "odd-lot" doctrine. Under that doctrine, a disabled person with some residual physical capacity may still be permanently and totally disabled due to a combination of her physical condition and certain nonmedical factors such as age, education, work experience, adaptability to nonphysical labor, mental capacity and emotional conditions. Clark v. Boise Cascade Co., 72 Or App 397 (1985).

Moreover, in order to qualify for permanent total disability benefits under the "odd-lot" doctrine, claimant must demonstrate that she is willing to re-enter the work force and that she has made reasonable efforts to do so. ORS 656.206(3). However, claimant's obligation to seek work may be excused when such attempts would, in all practicality, be futile. See Butcher v. SAIF, 45 Or App 318 (1983).

The first step in determining claimant's "odd-lot" status requires an evaluation of her physical condition. In September 1984, Dr. Manley opined that claimant's permanent impairment as a result of the 1980 injury was in the moderate range. As of October 1987, Dr. Manley reported that claimant was totally disabled. However, a physical capacities evaluation which he completed at the same time establishes that this latter opinion is not based upon physical factors alone. Dr. Manley reported that claimant could sit or walk for up to four hours each during an eight-hour workday, and that claimant could stand for up to two hours during an average workday. In addition, Dr. Manley opined that claimant could frequently lift up to 10 pounds, and that she could occasionally lift up to 20 pounds. These are not the restrictions of a person who is physically totally disabled.

Claimant notes that the Orthopaedic Consultants, who examined claimant in February 1987, also opined that claimant was totally disabled. However, claimant fails to note that the Consultants' panel attributed only moderate impairment to the compensable injury. The remainder of claimant's impairment they attributed to claimant's "marked psychological overlay." In this regard, claimant's vocational counselor reported that claimant overfocused on her physical pain and discomfort as a means to indicate that she is unable to perform work. The Northwest Pain Center reported that claimant "was prone to magnify the pain she was experiencing." Dr. Klein, psychiatrist, opined that claimant's "litany of symptoms is in service of final disability settlement." In addition, claimant's activities of back-packing, camping in a tent on her Washington property, and car trips to California and Washington exceed her professed capabilities. We conclude that claimant's functional overlay is volitional and, therefore, not compensable.

Claimant argues that her preexisting problems including obesity, chronic staph infections, and failing eyesight render her further impaired. In addition, claimant notes the disabling effect of her emphysema. For purposes of determining eligibility for permanent total disability benefits, preexisting "disabilities" are taken into consideration. ORS 656.206(1)(a). Disabilities resulting from preexisting conditions are considered as they existed at the time of the industrial injury. Walter R. Searles, 41 Van Natta 627, 629 (1989). Here, there is no persuasive evidence that any of claimant's preexisting conditions were disabling at the time of her 1980 injury. Similarly, claimant's emphysema did not develop until after her 1980 injury. In addition, there is no evidence that the emphysema is causally related to the injury. Consequently, we do not consider these conditions in assessing claimant's entitlement to permanent total disability benefits.

We, therefore, conclude that claimant's physical impairment resulting from her compensable 1980 injury is in the moderate range.

We turn next to the nonmedical factors to be considered in an "odd-lot" analysis. Claimant was 46 at the time of hearing. She completed the tenth grade in school and has since earned a GED. At the time of her injury, claimant had few skills transferable to sedentary or modified light employment activities. Since that time, however, she has undergone two on-the-job training programs and a five-month educational program. These experiences have greatly increased her transferable skills in the areas of bookkeeping, accounting, and other clerical skills. Further, she has consistently displayed very good aptitude for this type of sedentary and light activity. In this regard, shortly before closure of her vocational file, her rehabilitation counselor noted that "undoubtedly a State or Federal agency would be quite interested in looking at her closely for a possible permanent employment situation."

Despite claimant's involvement in vocational assistance activities, such activities did not result in successful job placement. Generally, this would be a factor weighing in favor of a finding of permanent total disability. However, claimant withdrew from such activities prior to completion in order to relocate to northeast Washington. Under these facts, we do not consider the lack of a successful job placement as persuasive evidence of permanent total disability status.

In sum, claimant is physically capable of performing sedentary to modified light employment. In addition, as a result of vocational rehabilitation efforts, she has transferable skills for such jobs. Moreover, her other nonmedical factors do not preclude such employments. We conclude that claimant is not permanently and totally disabled from regularly performing gainful and suitable employment.

Extent of Permanent Partial Disability

Considering our findings regarding claimant's injury-related impairment and the nonmedical factors pertinent to the evaluation of loss of earning capacity, we conclude that the Referee's award of 25 percent permanent partial disability, in addition to the prior award of 40 percent permanent disability, for a total award of 65 percent permanent partial disability, adequately and appropriately compensates claimant for her loss of earning capacity.

ORDER

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

BARBARA GUPTON, Claimant
Welch, Bruun & Green, Claimant's Attorneys
Steven D. Hallock, Defense Attorney

WCB 87-15238
August 31, 1989
Order on Review

Reviewed by Board Members Ferris and Crider.

Claimant requests review of Referee Thye's order that upheld a partial denial of a calcium deposit condition in claimant's left shoulder. On review, the issue is compensability. We affirm.

FINDINGS OF FACT

Claimant began working as an assembler for the employer

on June 23, 1987. Her work involved repetitive heavy lifting. During her first week of work, she experienced the onset of gradually worsening pain in her left arm and shoulder. She had no prior history of left arm or shoulder pain.

Claimant received treatment from a number of doctors, including Dr. Talley, M.D., and Dr. Gustafson, M.D. Both doctors diagnosed claimant's condition as tenosynovitis, which is a swelling of the tendon sheath caused by calcium deposits, repeated strain, or trauma. X-rays revealed large calcium deposits in claimant's left rotator cuff.

On August 25, 1987, the insurer formally accepted claimant's "recent exacerbation of [her] left shoulder symptoms due to [her] work activities." However, it denied claimant's "underlying condition of calcium deposits in [the] left shoulder." Claimant requested a hearing on the denial.

There is no evidence that the insurer has ever denied any claim for medical treatment or time loss related to claimant's current left shoulder condition.

FINDINGS OF ULTIMATE FACT

Claimant's underlying calcium deposit condition preexisted her work with the employer. Her work activity did not contribute to a worsening of that condition.

CONCLUSIONS OF LAW AND OPINION

The Referee concluded that claimant had not demonstrated that the calcium deposit condition in her left shoulder was compensable. We adopt his opinion subject to the following comment.

On review, claimant first argues that the Referee erred in analyzing her calcium deposit condition as an occupational disease. Claimant has misinterpreted the Referee's order. He did not analyze her condition as an occupational disease, rather than an injury, but instead concluded that this distinction is not relevant in this case. We agree.

The distinction between an injury and an occupational disease is important, primarily, because of a difference in the applicable standard of proof. If claimant's condition is analyzed as an injury, she need only demonstrate that her work activity materially contributed to her current symptoms. See Jameson v.SAIF, 63 Or App 553 (1983). If her condition is analyzed as an occupational disease, she must demonstrate that work activity is the major contributing cause of the onset or worsening of the condition. See Wheeler v. Boise Cascade Corp., 298 Or 452 (1985).

For the reasons discussed below, we agree with the Referee's ultimate conclusion that claimant has not demonstrated any relationship between her calcium deposit condition and her work activity. Accordingly, her condition is not compensable under either an injury or occupational disease theory. There is, therefore, no need to address claimant's contention that her condition is properly characterized as an injury.

We turn to the merits of the causation issue. This is a

complex medical question requiring expert medical opinion. Treating physicians Talley and Gustafson diagnosed claimant's symptoms as tenosynovitis, defined as a swelling of the tendon sheath caused by calcium deposits, repeated strain, or trauma. Dr. Talley attributed claimant's tenosynovitis to the combined effect of her work activity and calcium deposit condition. He indicated that the latter condition preexisted her work with the employer, and he stated that claimant would continue to experience inflammatory flare-ups if she continued the same type of work. Dr. Gustafson concurred in Dr. Talley's opinion. Neither doctor discussed whether claimant's work activity had worsened her underlying calcium deposit condition. The record contains no other medical opinions addressing the causation issue.

Accordingly, we conclude that the medical record does not support a causal relationship between claimant's work activity and the onset of her calcium deposit condition. Nor does the medical record support a work-related worsening of that condition. Claimant's work activity, instead, produced a separate tendinitis condition which has been accepted without reservation by the insurer. The insurer acted properly in issuing a partial denial of the calcium deposit condition.

ORDER

The Referee's order dated February 11, 1988 is affirmed.

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

WCB 87-02828
August 31, 1989
Order on Review

Reviewed by Board Members Ferris and Crider.

Claimant requests review of Referee Galton's order that affirmed a Determination Order that did not award permanent disability for a neck and right shoulder injury. The issue on review is the extent of unscheduled permanent disability. We affirm.

FINDINGS OF FACT

Claimant, sixty years of age at hearing with a 7th grade education, compensably injured his neck and right shoulder in 1985 after being struck by a falling pipe. He was off work as a liner operator/laborer for two days. Dr. Reynolds, family physician, reported tenderness in the shoulder girdle. Claimant continued to work. In November, 1986 a small fatty mass was removed from claimant's shoulder. He thereafter returned to work where he has worked for the past 20 years. Claimant's shoulder becomes symptomatic when he works overtime or must do very strenuous work. The March 30, 1987 Determination Order awarded temporary total disability only.

ULTIMATE FINDING OF FACT

The medical and lay evidence does not establish that, as a result of his compensable injury, claimant has either suffered any permanent impairment or that he has permanently lost earning capacity.

CONCLUSIONS OF LAW AND OPINION

The Referee found that, while claimant becomes symptomatic after strenuous work, he is not permanently impaired as a result of his compensable injury. Claimant argues on review that he proved a permanent loss of earning capacity. We disagree.

Dr. Reynolds, claimant's treating physician, reported shortly after claimant's injury that claimant would suffer permanent impairment of "5-8 percent." He repeated this opinion in later reports. However, after claimant's surgery in 1986, performed by Drs. Cohen and Reynolds, Dr. Reynolds declared claimant medically stationary on Feb 2, 1987, and reported no permanent impairment. Dr. Cohen opined that the fatty mass removed during the surgery was related to claimant's compensable condition, yet, Cohen did not report permanent impairment.

Claimant testified that he becomes symptomatic on days that are particularly strenuous, and he takes analgesics and uses a heat pack. He is able to continue working his regular job.

It is not necessary that the medical evidence by itself establishes a permanent loss of wage earning capacity for claimant to prove entitlement to an award of permanent disability. Garbutt v. SAIF, 297 Or 148 (1984). Claimant's testimony alone may or may not establish the existence of a permanent loss of earning capacity. Here, claimant's testimony supports the proposition that he experiences pain, but the pain is not disabling. See Harwell v. Argonaut Insurance Co., 296 Or 505 (1983).

Furthermore, claimant relies on the earlier opinions of his treating physician that he has suffered permanent impairment in the minimal range. However, after treating claimant for over one year and after performing surgery on his shoulder, Dr. Reynolds reported no permanent impairment. We find his later opinion, after the opportunity of treating claimant for an extended period and after operating on his shoulder, to be more informed and therefore more persuasive. Consequently, we agree with the Referee that claimant has not established entitlement to permanent disability as a result of his compensable condition.

ORDER

The Referee's order dated November 12, 1987, is affirmed. A client-paid fee, payable by the self-insured employer to its counsel, not to exceed $1,024, is approved.

KENNETH C. LEAHY, Claimant
Acker, Underwood, et al., Defense Attorneys

WCB 87-06338
August 31, 1989
Order on Review

Reviewed by Board Members Crider and Ferris.

Claimant, pro se, requests review of Referee Podnar's order that dismissed his request for hearing for failing to appear at the scheduled hearing. The issue on review is dismissal. We affirm.

Claimant has not established good cause for his failure to appear at the time and place set for hearing.

Claimant was notified that a hearing was scheduled for November 7, 1987. He did not appear for hearing. Claimant argues that because an independent medical examination (IME), previously scheduled for October 7, 1987, was cancelled in September, 1987, and not thereafter rescheduled, that he has established good cause for failing to appear for hearing. We disagree.

The cancellation of an IME had no impact on the hearing itself. The notice to claimant informing him that the IME was cancelled did not refer to the hearing. He makes no contention that he contacted the insurer and/or the Board about the hearing. Under these circumstances, we do not find that claimant has established "good cause" for failure to appear under former OAR 438-06-070. Accordingly, we conclude that the Referee properly dismissed the hearing request.

ORDER

The Referee's order dated November 20, 1987 is affirmed.

PAMELA R. STOVALL, Claimant
Malagon, et al., Claimant's Attorneys
Roberts, et al., Defense Attorneys
Foss, Whitty & Roess, Defense Attorneys

WCB 85-01254 & 84-13447
August 31, 1989
Order on Remand

This matter is before the Board on remand. Stovall v. Sally Salmon Seafood, 306 Or 25 (1988). The Supreme Court has affirmed the Court of Appeals decision, 84 Or App 612 (1987), which concluded that "[claimant] prevailed finally before the Board on her claim against Hallmark and, for that reason, is entitled to attorney fees under ORS 656.386(1), payable by Hallmark." 84 Or App at page 615. On remand, we have been directed to award attorney fees.

The attorney fee to which claimant is entitled is defined as an "assessed fee." OAR 438-15-005(2). Our rules provide that an assessed fee cannot be awarded without a statement of services. See OAR 438-15-010(5). Inasmuch as claimant's counsel has not submitted a statement of services, an assessed fee cannot currently be awarded. Consequently, once a statement of services is received and, assuming that we still retain jurisdiction over this case, we shall proceed with our consideration of this matter.

IT IS SO ORDERED.

DICK L. BARNETT, Claimant
Quintin Estell, Claimant's Attorney
Schwabe, et al., Defense Attorneys

WCB 85-16010
September 6, 1989
Order on Reconsideration

Claimant has requested reconsideration of our August 24, 1989 Order on Review which reversed that portion of a Referee's order which had set aside the insurer's "de facto" denial of claimant's aggravation claim for a right elbow condition and affirmed that portion of the Referee's order which assessed an attorney fee for failing to timely accept or deny the claim. Claimant contends that his aggravation claim is compensable and that, in any event, he is entitled to an attorney fee for his counsel's efforts on review for prevailing on the attorney fee issue.

On a "technical" matter, claimant asserts that, due to recent resignations of members of the Board, he has been "deprived of the possibility of all three members of the Board considering this case." Yet, the participation of all three members is not required. Rather, the act or decision of any two of the Board members shall be deemed the act or decision of the Board. ORS 656.718(2). Moreover, each member shall hold office until a successor is appointed and qualified. ORS 656.712. Such qualification includes taking and ascribing to the oath or affirmation provided in ORS 656.716(2), which must also be filed in the office of the Secretary of State. See ORS 656.716(3). In addition, all appointments are subject to Senate confirmation. ORS 656.712(4).

Here, Member Ferris had submitted her resignation when our August 24, 1989 order issued. However, at that time, the appointment of her successor had not received Senate confirmation nor had her successor been "qualified." Consequently, Member Ferris was authorized to participate in the review of this case. See ORS 656.716(2), (3). Furthermore, since two authorized members participated in the resolution of this case, their decision constitutes the decision of the Board. See ORS 656.718(2). Because the successor to Member Ferris still has not been "qualified", this order also constitutes the decision of the Board.

Turning to the "merits" of claimant's request, we continue to adhere to the reasoning and conclusions expressed in our prior order concerning the aggravation issue. We provide the following supplementation concerning claimant's contention that he is entitled to an attorney fee for successfully defending the Referee's award of an assessed fee on a penalty issue.

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

Accordingly, the motion for reconsideration is granted and our August 24, 1989 order is withdrawn. On reconsideration, as supplemented herein, we adhere to and republish our August 24, 1989 order, effective this date. The parties' rights of appeal shall run from the date of this order.

IT IS SO ORDERED.

VICTOR S. LLOYD, Claimant
Hampson, Bayless, et al., Claimant's Attorneys
Schwabe, et al., Defense Attorneys
James R. Jennings, Attorney
Cooney, et al., Attorneys

WCB TP-89022
September 6, 1989
Third Party Distribution Order

Reviewed by Board Members Ferris and Crider.

The paying agency has petitioned the Board to resolve a dispute concerning a purported third party settlement. See ORS 656.587; 656.593. The paying agency contends that the settlement between claimant and the Professional Liability Fund (the malpractice insurer for claimant's attorney in the third party lawsuit) is void for want of prior approval by the paying agency.

The Professional Liability Fund ("the Fund"), on behalf of claimant, argues that the Board lacks jurisdiction to address the issue. Alternatively, the Fund asserts that the paying agency's lien does not extend to the settlement proceeds.

We conclude that we may properly exercise jurisdiction over this matter and that the paying agency's lien attaches to the proceeds of the settlement in question. Moreover, the settlement agreement is void because it was not made with the approval of the paying agency.

FINDINGS OF FACT

Claimant injured his right hand and wrist on August 8, 1983, while lowering a warehouse door at work. He filed a workers' compensation claim which was accepted by the self-insured employer. Compensation benefits were provided.

On November 29, 1983, claimant's then-attorney notified the employer that claimant elected to pursue a third party claim against the party or parties responsible for the accident. Subsequently, on August 7, 1985, claimant's attorney commenced a third party action against several third parties by the filing of a complaint in circuit court.

On September 20, 1985, claimant's attorney filed an amended complaint which substituted a new defendant in the place of one of the prior defendants.

On October 16, 1985, claimant's attorney filed a second amended complaint which substituted an additional defendant in the place of a prior defendant.

On December 9, 1985, judgment was entered in favor of one of the third party defendants. On March 31, 1986, claimant's complaint against the remaining defendants was dismissed by the court.

Thereafter, claimant asserted a legal malpractice claim against the attorney who had represented him in the third party matter. Claimant's former attorney was insured for malpractice through the Fund.

On October 15, 1986, a Determination Order issued in claimant's workers' compensation matter which terminated claimant's entitlement to temporary total disability benefits. Claimant requested a hearing to challenge this Determination Order. An attorney with the same law firm representing claimant in his legal malpractice claim represented claimant on the continuing workers' compensation matter.

On October 30, 1986, the employer, as paying agency on the workers' compensation matter, notified claimant's counsel that it was asserting a third party lien against any recovery in the legal malpractice claim.

Claimant and the employer subsequently entered into a settlement agreement in the workers' compensation matter whereby claimant dismissed his hearing request. In return, the employer agreed to reduce its third party lien from $11,608.82 to $4,000, plus future expenses.

On January 31, 1989, claimant's counsel informed counsel for the employer/paying agency that the malpractice action had been settled with the Fund. The settlement agreement provided for claimant to receive $10,000 and claimant's counsel to receive attorney fees in the amount of $5,000. No provision was made for any sum to be paid to the employer/paying agency.

The employer/paying agency subsequently petitioned the Board for relief pursuant to ORS 656.576 to 656.595.

FINDINGS OF ULTIMATE FACT

Claimant's malpractice claim against his former attorney was ancillary to his third party action.

CONCLUSIONS OF LAW AND OPINION

If a worker receives a compensable injury due to the negligence or wrong of a third person not in the same employ, the worker shall elect whether to recover damages from such third person. ORS 656.578. If the worker elects to pursue a third party action, and if the worker settles the third party claim, 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(1); Estate of Troy Vance v. Williams, 84 Or App 616, 619-20 (1987). Any settlement by the worker is void unless made with the written approval of the paying agency or, in the event of a dispute between the parties, by order of the Board. ORS 656.587.

The paying agency argues that claimant's settlement with the Fund is void because it was not made pursuant to either written approval from the agency or Board order. In response, the Fund contends that the paying agency's statutory lien does not extend to a recovery against an attorney, or the attorney's insurer, for damages resulting from alleged malpractice arising out of the third party action.

A similar factual situation involving settlement of a legal malpractice claim was presented to us recently in Charlene Toole, 41 Van Natta 1392 (August 17, 1989). In Toole, we discussed the Court of Appeals' decision in Shipley v. SAIF, 79 Or App 149, rev den 301 Or 338 (1986). Claimant in Shipley recovered a judgment for the negligence of a third party defendant. However, the insurer for the third party defendant refused to pay the judgment. Claimant then filed an action against the insurer on the policy. A jury found in favor of claimant and awarded him the amount of the original judgment plus interest.

SAIF, the paying agency on the underlying claim, asserted its statutory lien on the recovery. Claimant objected to SAIF's lien. Claimant argued that the lien can only arise out of an action for the "negligence or wrong of a third person" and not out of an action by the beneficiary of an insurance contract. We rejected claimant's argument and held that SAIF had a valid lien. Claimant sought judicial review.

On review, the court affirmed. The court reasoned as follows (79 Or App at 152):

"Plaintiff elected to seek recovery against the third party, and he successfully obtained an award of damages for the negligently inflicted injury. Only because the third party's insurer denied coverage did plaintiff have to initiate an action to recover the amount of the judgment. That action was ancillary to the action against the insured, because, without the judgment against the insured, no cause of action against the insurer could have existed. Plaintiff's ultimate recovery of damages arose out of the negligent conduct of the third party, and the proceeds are properly subject to a lien by SAIF."

Based upon our interpretation of Shipley, we concluded in Toole that a paying agency's lien extends to a malpractice settlement entered into between a claimant and the Fund.

Here, the Fund presents the same arguments as were presented in Toole. We are not persuaded by those arguments. We continue to hold that a paying agency's lien extends to a malpractice settlement entered into between a claimant and the Fund. We adopt our discussion in Toole in this regard. Because the employer/paying agency was not allowed an opportunity to approve or disapprove the settlement agreement, the agreement is void.

The Fund further contends that, if the paying agency retains a valid lien on the settlement proceeds, the lien should be limited to the $4,000 figure agreed to in settlement of the workers' compensation claim. The employer/paying agency argues that the workers' compensation settlement agreement was breached by claimant's attorney's failure to distribute the agreed-upon $4,000 to the employer/paying agency out of the legal malpractice settlement proceeds. Consequently, the paying agency asserts entitlement to the full amount of its lien, $11,608.82.

We agree with the Fund that the paying agency's lien is limited to the $4,000 figure, plus future expenses, as agreed upon in the workers' compensation settlement. The true consideration for the paying agency's agreement to reduce its lien was the dismissal of claimant's hearing request challenging the October 15, 1986 Determination Order. Claimant performed his part of the agreement by dismissing his hearing request. Although it was anticipated that the paying agency would recover its lien from settlement of the legal malpractice claim, this was not the consideration for the workers' compensation settlement agreement. Under these circumstances, we conclude that it would not be "just and proper" to allow the paying agency to assert entitlement to its full lien as against any future settlement of the legal malpractice claim. See ORS 656.593(3).

IT IS SO ORDERED.

BENITA C. McGOWAN, Claimant
Martin McKeown, Claimant's Attorney
Jeff Gerner (SAIF), Defense Attorney

WCB 86-16850
September 6, 1989
Order on Review

Reviewed by Board Members Crider and Ferris.

Claimant requests review of Referee Foster's order which upheld the SAIF Corporation's denial of claimant's medical services claim for a power steering unit for her car. On review, the sole issue is compensability. We affirm.

FINDINGS OF FACT

Claimant sustained a compensable injury to her neck and upper back in January 1984. This claim was first closed by a August 1984 Determination Order which awarded claimant time loss compensation, as well as 5 percent unscheduled permanent disability. In December 1984, a prior Referee increased claimant's award to 30 percent unscheduled permanent disability.

In September 1984, Dr. Ray, chiropractor, prescribed a power steering unit for claimant's car. This prescription was not received by SAIF until August 1986.

SAIF denied compensability of the power steering unit on the basis that it was not medically necessary.

FINDINGS OF ULTIMATE FACT

A power steering unit is not reasonable and necessary as a result of claimant's compensable injury.

CONCLUSIONS OF LAW

The Referee concluded that a power steering unit was not reasonable and necessary as a result of claimant's compensable injury. We agree.

For every compensable injury, the insurer or self-insured employer shall cause to be provided medical services for conditions resulting from the injury for such period as the nature of the injury or the process of recovery requires. ORS 656.245(1). Medical services are compensable provided 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 medical services are reasonable and necessary. James v. Kemper Ins. Co., 81 Or App 80, 81 (1986).

Following our de novo review, we conclude that claimant has failed to to meet her burden of proof. Dr. Ray, who originally wrote the prescription in September 1984, indicated that the power steering unit would not cure claimant's difficulties, but would make driving easier and more comfortable, as well as reducing the likelihood of reinjury. Dr. Hollingsworth, chiropractor, concurred with Dr. Ray's assessment and noted that a power steering unit would reduce the likelihood of exacerbations. Finally, Dr. Vargo, claimant's earlier treating physician, indicated that claimant did not need the power steering unit. We consider this latter opinion from an attending physician, albeit conclusory, to be persuasive.

In light of this, we find that claimant has not carried

her burden of proving that the power steering unit is reasonable and necessary as a result of her compensable injury. Accordingly, the "power steering unit" is not compensable.

ORDER

The Referee's order dated October 13, 1987 is affirmed.

FAYE L. BALLWEBER, Claimant
Olson, et al., Claimant's Attorneys
Liberty Northwest, Insurance Carrier

Own Motion 89-0107M
September 7, 1989
Own Motion Order

The insurer has submitted to the Board claimant's claim for an alleged worsening of her September 11, 1981 industrial injury. Claimant's aggravation rights have expired. The insurer has accepted responsibility for the surgery but opposes payment of temporary disability benefits on the ground that claimant has withdrawn from the work force.

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

Following our review of this record, we are persuaded that claimant's compensable injury has worsened requiring surgery. In addition, claimant has submitted copies of wage statements from the year 1988 documenting employment. We conclude claimant has shown sufficient participation in the work force to establish that she has not withdrawn from the workforce. Accordingly, claimant's claim is reopened with temporary disability benefits to commence December 22, 1988, the date she was hospitalized for surgery, and to continue until claimant returns to her regular work at her regular wage or is medically stationary, whichever is earlier. Reimbursement from the Reopened Claims Reserve is authorized to the extent allowed under ORS 656.625 and OAR 436, Division 45. When appropriate, the claim shall be closed by the insurer pursuant to OAR 438-12-055.

IT IS SO ORDERED.

LOREN CALLIHAN, Claimant
Pozzi, et al., Claimant's Attorneys
Beers, et al., Defense Attorneys

WCB 89-01676
September 7, 1989
Order Denying Motion to Dismiss

Reviewed by Board Members Ferris and Crider.

Claimant has moved the Board for an order dismissing the insurer's request for review of a Referee's order on the grounds that the issue raised by the request has been rendered moot by events which have occurred after the issuance of the Referee's order. We deny the motion.

FINDINGS

Claimant requested a hearing, contending that the insurer improperly failed to submit his cervical claim for closure. Following the hearing, the Referee directed that the insurer submit the

aforementioned claim to the Evaluation Section for closure. In addition, claimant was awarded an insurer-paid attorney fee of $1,900.

The insurer requested Board review within 30 days of the Referee's order. Thereafter, in compliance with the Referee's order, the insurer submitted the claim for closure. On July 5, 1989, a Determination Order issued, awarding claimant 31 percent unscheduled permanent disability.

CONCLUSIONS

Since it has appealed the Referee's order, the insurer contends that it is entitled to have the issues raised therein addressed. It further asserts that these issues should be resolved, regardless of subsequent developments in the case. We agree.

Because the insurer timely requested Board review, the Referee's order has not become final. See ORS 656.289(3). After conducting our review, we are authorized to affirm, reverse, modify or supplement the Referee's order, as well as make such disposition of the case as it determines to be appropriate. ORS 656.295(6). Consequently, the issues raised and addressed in the Referee's order remain viable.

Despite its appeal, the insurer is required to comply with the Referee's order. ORS 656.313(1); Weyerhaeuser Company v. McCullough, 92 Or App 204 (1988); Theodore W. Lincicum, 40 Van Natta 1953 (1988). Thus, the insurer's action in processing the claim to closure does not deprive the insurer of its right of appeal.

Moreover, the statute does not require that the attorney fee be paid pending appeal. The fee award is derivative of the Referee's conclusions on the processing issue. For that reason also, the case is not moot.

Were we to accede to claimant's wishes and dismiss the insurer's request for review, we would be denying the insurer its statutory right to appeal from a Referee order. In addition, a dismissal under these circumstances could be interpreted as encouraging parties to ignore Referee orders, which is a message we do not wish to send. See Theodore W. Lincicum, supra.

The fact that subsequent actions have been lawfully taken in response to an appealed Referee's order does not resolve the question of whether the conclusions reached in that order were appropriate in the first instance. Rather, that question remains subject to our jurisdiction. See ORS 656.289(3); 656.295(6).

Accordingly, the motion to dismiss is denied. Inasmuch as the briefing schedule has been completed, this case shall be docketed for Board review.

IT IS SO ORDERED.

RICHARD R. INGALLS, Claimant
Pozzi, et al., Claimant's Attorneys
Alan Ludwick (SAIF), Defense Attorney

WCB 86-03202
September 7, 1989
Fourth Interim Order (Remanding)

Claimant has moved the Board for the abatement of our August 24, 1989 Third Interim Order (Remanding) which remanded this case to the Hearings Division with instructions to reconvene a hearing. This action was necessary because the hearing reporter had provided only a partial transcript of the prior hearing. Specifically, claimant seeks the issuance of a subpoena to the hearing reporter directing him to appear and show cause why an action for contempt should not be initiated against him in Circuit Court pursuant to ORS 656.732. We deny the motion.

In support of his request, claimant relies upon ORS 656.726 and 656.732. Our review of these statutes does not lead us to the conclusion that we have the authority to take the action claimant desires.

ORS 656.732 provides that the circuit court on application of the Board shall compel obedience to subpoenas issued and served pursuant to ORS 656.726. The Board is empowered to issue and serve subpoenas for the attendance of witnesses and the production of papers, contracts, books, accounts, documents and testimony before any hearing under ORS 654.001 to 654.295, 654.750 to 654.780 and 656.001 to 656.794. ORS 656.726(2)(c). This statute makes no reference to hearing reporters nor do we consider the current circumstances to be within the parameters of the Board's subpoena authority.

The Board has power to generally provide for the taking of testimony and for the recording of proceedings. ORS 656.726(2)(d). In keeping with this authority, the Board enters into contractual arrangements with hearing reporters. Such a procedure was followed here. Unfortunately, in this particular instance, the reporter has refused to comply with his contractual obligations. As stated in our March 24, 1988 order, since the reporter was an independent contractor, our remedy rests in a civil cause of action for breach of contract rather than contempt procedures.

Accordingly, our August 24, 1989 order is withdrawn. Upon reconsideration, as supplemented herein, we adhere to and republish our August 24, 1989 order, effective this date.

IT IS SO ORDERED.

RONALD M. LYDAY, Claimant
Mark R. Malco, Claimant's Attorney
Cummins, et al., Defense Attorneys

WCB 88-04125
September 7, 1989
Order of Dismissal (Remanding)

Reviewed by Board Members Crider and Ferris.

Claimant has moved the Board for an order dismissing the insurer's request for review of Referee Quillinan's July 31, 1989 order. Claimant contends that the Referee lacked authority to issue the order. In addition, the insurer seeks "clarification of jurisdiction" concerning this matter. We conclude that the Referee had jurisdiction to issue the July 31, 1989 order. However, because the order is not a final order, we remand.

FINDINGS

On April 20, 1989, the Referee issued an Opinion and Order. The insurer moved for reconsideration of the order on April 21, 1989. On May 5, 1989, the Referee denied the reconsideration motion. That same day, the insurer also withdrew its motion.

On May 12, 1989, the insurer submitted a motion to the Presiding Referee, seeking abatement of the Referee's April 20, 1989 order. The insurer also asked that the case be reassigned to another Referee.

On May 18, 1989, the Referee issued an Order of Abatement. Referring to the insurer's motion, the Referee abated the April 20, 1989 order to permit claimant to respond to the insurer's recent motion and to allow the Presiding Referee an opportunity to consider the matter. Thereafter, claimant's counsel's response was received by the Presiding Referee.

On July 20, 1989, the Presiding Referee denied the insurer's motion for a change of Referees. Reasoning that the insurer's motion was untimely, the Presiding Referee referred the matter to the Referee for the issuance of a final order.

On July 31, 1989, the Referee republished the "May 18, 1989" order in its entirety. On August 11, 1989, the insurer requested Board review of the Referee's July 31, 1989 order, as well as the Presiding Referee's July 20, 1989 order.

ULTIMATE FINDINGS

The Referee's April 20, 1989 order was abated within 30 days of its issuance. The Referee's May 18, 1989 and July 31, 1989 orders, as well as the Presiding Referee's July 20, 1989 order, did not finally deny or allow a claim, nor did they fix the amount of claimant's compensation.

CONCLUSIONS

A Referee's order is final unless, within 30 days after the date on which a copy of the order is mailed to the parties, one of the parties requests Board review under ORS 656.295. ORS 656.289(3). The time within which to appeal an order continues to run, unless the order has been stayed, withdrawn, or modified. International Paper Company v. Wright, 80 Or App 444 (1986); Fischer v. SAIF, 76 Or App 656 (1985). 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, on May 5, 1989, the Referee denied the insurer's April 21, 1989 motion for reconsideration of the April 20, 1989 order. However, in direct response to the insurer's subsequent motion to the Presiding Referee for abatement and a change of Referee, the Referee expressly abated the April 20, 1989 order. Inasmuch as the Referee's abatement order issued on May 18, 1989, which was within 30 days from April 20, 1989, we conclude that the statutory appeal period from the April 20, 1989 order had been tolled.

Claimant contends that the Referee's abatement order was "issued without legal authority." We disagree.

As previously noted, the Referee expressly abated the April 20, 1989 order to permit claimant to respond to the insurer's motion for abatement and change of Referee and to allow the Presiding Referee an opportunity to consider the matter. Moreover, a Referee may reconsider a decision, on his/her own motion, before a request for review is filed or, if none is filed, before the time for requesting review expires. OAR 438-07-025(1). Thus, under either of the aforementioned approaches, the Referee had authority to abate the April 20, 1989 order.

We turn to the issue of whether the orders issued by the Presiding Referee and the Referee after May 18, 1989 are final appealable orders. We answer that question in the negative.

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 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 (1974).

Here, the Presiding Referee's July 20, 1989 order denied the insurer's motion for a change of Referee. In addition, the Presiding Referee referred the case to the Referee for the issuance of a final order. Because the Presiding Referee's order neither finally disposed of, nor allowed, a claim, nor fixed the amount of claimant's compensation, we conclude that it was not a final appealable order.

Furthermore, the Referee's July 31, 1989 order republished the May 18, 1989 order. Since the May 18, 1989 order was an abatement order, the Referee's July 31, 1989 order also neither finally disposed of, nor allowed, the claim, nor fixed the amount of claimant's compensation.

Inasmuch as further action before the Hearings Division is required as a result of both the Presiding Referee's July 20, 1989 order and the Referee's July 31, 1989 order, we hold that neither are final, appealable orders. 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 Quillinan for further action.

IT IS SO ORDERED.

FLOYD E. MILLER, Claimant
Doblie & Associates, Claimant's Attorneys
Judy L. Johnson (SAIF), Defense Attorney

WCB 87-16907
September 7, 1989
Order on Review

Reviewed by Board Members Crider and Ferris.

Claimant requests review of those portions of Referee Mulder's order that upheld the SAIF Corporation's "de facto" denial of chiropractic treatment in excess of OAR 436-10-040(2)(a). The issue on review is medical services. We reverse.

FINDINGS OF FACT

Claimant compensably injured his low back on April 20, 1987. He treated with Dr. Bolera, chiropractor, who treated claimant about three times weekly.

On May 28, 1987, SAIF wrote Dr. Bolera requesting a report on his treatment plan for claimant. On June 4, 1987, Dr. Bolera wrote SAIF describing a treatment plan in excess of the administrative guidelines. SAIF did not respond to this letter.

On August 6, 1987, SAIF sent Dr. Bolera a form letter indicating it could not process further billing without receiving his chart notes for the period June 5, 1987 to July 9, 1987.

On October 6, 1987, SAIF sent an identical letter indicating it needed chart notes from August 4, 1987 to October 6, 1987, to process billing.

On September 12, 1987, claimant was examined by the Western Medical Consultants. They opined that claimant was not medically stationary and that medical treatment within the administrative guidelines would be sufficient. SAIF referred a copy of this report to Dr. Bolera. He responded on October 20, 1987, indicating he disagreed with portions of the report and further outlined how he intended to treat claimant.

On November 20, 1987, SAIF notified Dr. Bolera by letter that ". . . we will only allow treatment on a palliative basis of approximately two times per month." Claimant thereafter filed a request for hearing, alleging unreasonable denial of chiropractic services.

ULTIMATE FINDINGS OF FACT

All chiropractic services rendered up to November 20, 1987, are presumed to be reasonable and necessary.

Chiropractic treatments rendered after November 20, 1987, in excess of the Director's guidelines, were not reasonable and necessary medical services.

CONCLUSIONS OF LAW AND OPINION

The Referee determined that chiropractic treatments in excess of the administrative guidelines were not reasonable and necessary. Claimant argues that under OAR 436-10-040(2)(a), those services, at least until the letter of November 20, 1987, are presumed reasonable and necessary. We agree. That rule states:

> "Frequency and extent of treatment shall not be more than the nature of the injury and 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."

When SAIF first asked Dr. Bolera for a report on May 28, 1987, he responded with a treatment plan on June 4, 1987. Pursuant to the administrative guideline, SAIF then had 30 days to indicate disagreement with the proposed treatment schedule. SAIF essentially did nothing until it forwarded a copy of an independent medical examination to Dr. Bolera on October 6, 1987. We treat this as a request for a report, since the report of the Western Medical Consultants indicates reduced chiropractic treatment was indicated.

Upon receipt of this report, Dr. Bolera responded, again outlining his proposed treatment plan. SAIF disagreed with this plan on November 20, 1987. We find that all treatment prior to that date is presumed reasonable and necessary under the administrative rule. We therefore reverse the Referee's order insofar as it upheld SAIF's "de facto" denial of these services.

As to chiropractic treatments, rendered after November 20, 1987, the Referee in effect upheld SAIF's "de facto denial" of these services. Compare John D. Ellis, 39 Van Natta 319 (1987); affirmed Ellis v. McCall Insulation, 93 Or App 188 (1988), 308 Or 74 (1989). We agree that claimant did not prove that chiropractic services in excess of the Director's guidelines rendered after November 20, 1987, were reasonable and necessary.

Claimant relies on the reports of Dr. Bolera and his associate, Dr. Skelton, to establish that claimant's need for treatment is extraordinary compared to other injured workers. We disagree. The reports of an independent consulting panel and Dr. Fechtel, chiropractor, indicate that claimant may need continuing palliative treatment but found no cause for treatment beyond the Director's guidelines. We find the medical reports of the independent examiners to be more persuasive because they focus more on claimant's objective condition. Dr. Bolera's reports do not establish that his treatment is curative and do not explain how palliative treatment in excess of the guidelines will actually benefit claimant. Accordingly, we conclude that chiropractic treatment in excess of the Director's guidelines after November 20, 1987, were not reasonable or necessary.

ORDER

The Referee's order dated March 7, 1988, is reversed in part. The SAIF Corporation is ordered to pay for all services billed by Dr. Bolera prior to November 20, 1987. For services at hearing and on Board review, concerning the chiropractic treatment issue, claimant's attorney is awarded a reasonable assessed fee of $1,500, to be paid by SAIF. The remainder of the Referee's order is affirmed.

FLOYD D. MITCHELL, Claimant
Charles D. Maier, Claimant's Attorney
Garrett, et al., Defense Attorneys

WCB 87-17570
September 7, 1989
Order on Review

Reviewed by Board Members Ferris and Crider.

Claimant requests review of Referee Baker's order that dismissed his hearing request with prejudice. The sole issue is whether claimant's claim for medical services rendered prior to the stipulated order of August 28, 1987, is barred by res judicata. We affirm.

FINDINGS OF FACT

Claimant compensably injured his low back in October, 1986. He was taken off work and treated thrice weekly with Dr. Stellflug, a chiropractor. In early 1987 the insurer wrote Stellflug several letters requesting justification for treatment frequency beyond the Department's guidelines of two office visits per month. No response to those letters was received. The claim was closed by Determination Order on May 8, 1987, with no permanent disability award.

In March, 1987, the insurer began reducing payments to Dr. Stellflug for treatment, resulting in a steady increase of the amount of outstanding charges. In May, 1987, claimant filed a request for hearing asserting, inter alia, entitlement to further medical treatment under ORS 656.245. In June, 1987, Stellflug wrote the insurer that his treatment frequency was justified by an MRI study showing probable disc herniation at L5-S1. However, that diagnosis was subsequently negated by a myelogram performed by Dr. Poulson, an orthopedist. On June 29, 1987, the insurer wrote Stellflug that it would continue to pay for two office visits per month, absent justification for more frequent treatment.

On August 28, 1987, a prior Referee approved a stipulated order whereby the parties agreed, inter alia, that all issues raised by claimant's May, 1987, hearing request and all issues that could have been raised up to the date of the order were conclusively deemed settled or waived. Claimant further agreed to advise his medical service providers of the terms of the order and to "hold harmless and indemnify [the insurer] in any action taken by any such health care provider against [the insurer] for outstanding medical services which have not been previously justified as reasonable and necessary to treatment of the compensable condition." The order also provided for dismissal of claimant's pending hearing request.

On September 30, 1987, the insurer wrote Stellflug that it continued to pay for treatment within the Department's guidelines and that treatment beyond those guidelines was excessive and nonpayable. Claimant subsequently filed the current hearing request, seeking medical services in excess of two treatments per month and a penalty and attorney fee for the insurer's refusal to pay for the same.

At hearing, the insurer's counsel represented that medical bills for treatments in excess of two per month rendered after the date of the stipulated order were being processed by his client. In an effort to preserve issues relating to the frequency

of post-order treatments, the parties stipulated at hearing that those issues shall not be deemed raised or raisable in this case.

CONCLUSIONS OF LAW AND OPINION

The sole issue is whether the doctrine of res judicata bars claimant from now asserting his medical services claim for treatments in excess of two per month rendered prior to the date of the stipulated order.

The doctrine of res judicata precludes relitigation of claims and issues previously adjudicated. North Clackamas School Dist. v. White, 305 Or 48, 50, on recon 305 Or 406 (1988). The preclusive effect of a prior adjudication on a claim is called "claim preclusion." Id.; Restatement (Second) of Judgments, Introduction at 1-5 (1982). The rule of claim preclusion is that if a claim is litigated to final judgment, the judgment precludes a subsequent action between the same parties on the same claim or any part thereof. Restatement (Second) of Judgments, §§ 17-19, 24; see also Carr v. Allied Plating Co., 81 Or App 306, 309 (1986); Million v. SAIF, 45 Or App 1097, 1102, rev den 289 Or 337 (1980). A Referee's order approving a disputed claim settlement and dismissing claimant's request for hearing is a "judgment" within the meaning of the above rule. See ORS 656.289(4); Proctor v. SAIF, 68 Or App 333, 335-36 (1984); Tana L. Wilson, 40 Van Natta 476, 478 (1988).

Here, the order provides that claimant shall indemnify the insurer in any action by a health care provider for outstanding medical services which have "not been previously justified as reasonable and necessary to treatment of the compensable condition." The quoted phrase apparently refers to treatments in excess of the Department's guidelines of two visits per month. Hence, the order is a final judgment on the responsibility for payment of treatments exceeding the guidelines. Claimant is now precluded from asserting his claim for those treatments.

ORDER

The Referee's order dated February 22, 1988, is affirmed. The Board approves a client-paid fee not to exceed $758.50.

AMRAT & MINA A. PATEL, dba,
Comfort Inn & Fireside Motel, Employer
DELORES E. SLY, Claimant
Milo Pope, Claimant's Attorney
Stephen Finlayson, Employer's Attorney
SAIF Corp Legal, Defense Attorney

WCB 85-00145
September 7, 1989
Order on Review

Reviewed by Board Members Crider and Ferris.

Amrat and Mina Patel, the alleged noncomplying employers, request review of Referee Wasley's order that: (1) found them to be a noncomplying employer; and (2) found that claimant had suffered a compensable low back injury. The issues on review are coverage, jurisdiction, and compensability. We affirm the Referee's order.

FINDINGS OF FACT

The Board adopts the findings of the Referee with the following supplementation.

On January 4, 1985, the Board received the noncomplying employer's request for hearing objecting to the SAIF Corporation's acceptance of the claim and the amount of compensation awarded by a Determination Order issued October 1, 1985. However, the request did not deny claimant's injury claim, nor did it inform claimant of her hearing rights. Furthermore, a copy of the request was not mailed to claimant.

CONCLUSIONS OF LAW AND OPINION

The Referee found the employer to be noncomplying and the claim compensable. On review, the noncomplying employer argues that claimant was not injured at work and thus is not entitled to disability benefits. We adopt the Referee's conclusions with the following supplementation concerning the compensability issue.

Derryberry v. Dokey, 91 Or App 533 (1988) addresses the issue of denial of a claim by a noncomplying employer. A denial must inform the claimant of hearing rights and must be mailed to the claimant former ORS 656.262(8). The court found that since SAIF properly accepted the claim and no party had ever properly denied it, claimant was entitled to compensation. A letter to the Workers' Compensation Board requesting a hearing does not satisfy the Derryberry requirement. See also Darrell E. Breymier, 40 Van Natta 1164 (1988)

In the present case, the Board received the noncomplying employer's request for hearing on January 4, 1985. The request did not inform claimant of hearing rights. No copy of the request was mailed to claimant. Since no proper denial of compensability was made, we hold that claimant is entitled to compensation. Consequently, it is unnecessary to address the merits of the compensability issue.

ORDER

The Referee's order dated December 2, 1987 is affirmed. For services on Board review, claimant's attorney is awarded a reasonable fee of $340, to be paid by the SAIF Corporation, on behalf of the noncomplying employer.

DELORES M. SHUTE, Claimant
William H. Summerfield, Claimant's Attorney
James E. Griffin, Assistant Attorney General

WCB TP-89030
September 7, 1989
Third Party Distribution Order

Reviewed by Board Members Crider and Ferris.

Claimant has petitioned the Board for resolution of a conflict concerning the "just and proper" distribution of proceeds from a third party settlement. See ORS 656.593(3). Contending that there was a substantial possibility that she would not have prevailed against the third party, claimant suggests that the paying agency's lien against the remaining balance of proceeds from the settlement should be reduced. We conclude that a distribution of settlement proceeds in accordance with ORS 656.593(1) is just and proper.

FINDINGS OF FACT

In August 1987, while performing her employment duties as an assistant manager for a video store, claimant slipped and fell down a flight of stairs. Her condition was diagnosed as lumbar strain with sciatica. The claim was accepted.

Claimant, through her legal counsel, brought suit against a third party, the owner/lessor of the building. With SAIF's approval, claimant and the third party have settled the cause of action for $7,500.

SAIF's "third party" lien for its claim costs totals $5,205.33. The amount of this lien is not contested. After deduction for claimant's attorney fees, litigation costs, and statutory 1/3 share, a balance of $3,748.88 remains.

A distribution of the remaining balance of the third party settlement proceeds to SAIF is just and proper.

CONCLUSIONS OF LAW

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

The statutory formula for distribution of a third party recovery obtained by judgment, ORS 656.593(1), is generally applicable to the distribution of a third party recovery obtained by settlement. Robert L. Cavil, 39 Van Natta 721 (1987). ORS 656.593(1) provides in exact detail how, and in what order, the proceeds of any damages shall be distributed.

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

As previously noted, we generally apply the statutory formula for distribution of a third party judgment, ORS 656.593(1), to the distribution of proceeds from a third party settlement. Robert L. Cavil, supra. We take such an approach to avoid making "equitable distributions on an ad hoc basis" and to permit the parties to generally know where they stand as they seek to settle a third party action. See Marvin Thornton, 34 Van Natta 34 Van Natta 999, 1002 (1982). On rare occasions, circumstances may justify a departure from the statutory distribution formula. See Robert T. Gerlach, 36 Van Natta 293, 296 (1984) (Paying agency's lien reduced to "in effect, reconstruct an agreement the

parties substantially entered into, but which subsequently fell apart primarily due to an unfortunate failure of communication.")

Here, claimant challenges the paying agency's entitlement to the remaining balance of proceeds from the third party settlement. Asserting that there was "a substantial possibility of a defense verdict" had she chosen to continue to pursue the third party litigation, claimant contends that SAIF's lien should "automatically be reduced by fifty percent."

We find no persuasive reason to depart from our general approach of resolving distribution conflicts in accordance with the statutory formula. Therefore, we conclude that a distribution in accordance with ORS 656.593(1) is just and proper.

In essence, claimant is advocating a position that is available to any party in a dispute involving the distribution of a third party recovery, i.e., it would be more equitable to order a distribution that results in her receipt of a larger portion of the third party settlement. We have consistently rejected such an argument, reasoning that, in the long run the results would be random, standardless, and, thus, inequitable. See John C. Adams, 40 Van Natta 1794 (1988), aff'd mem Liberty Northwest v. Adams, 97 Or App 587 (July 19, 1989); William C. Smith, 40 Van Natta 1259 (1988).

As we recently reiterated in Chris A. Meirndorf, 41 Van Natta 962 (June 8, 1989), our reasoning is based on the following principles. Under the statutory distribution formula, the parties generally know where they stand. On the other hand, if the parties knew only that each would receive that portion of the settlement that the current Board then regarded as equitable, settlement of a third party action would at least be more difficult, if not impossible. Marvin Thornton, supra at page 1002.

Claimant proposes the implementation of this so-called "fifty percent" standard as a method of distributing third party settlements in a manner that "equitably reflect[s] the real risks of litigation faced by plaintiffs with tenuous claims." We reject the proposal.

To begin, we are unable to discern a logical correlation between a worker's comparative negligence and the amount of a paying agency's lien. A worker's negligence, or lack thereof, is solely an issue for resolution between the worker and the third party. Moreover, it is one of the risks which naturally accompanies the worker's election to proceed against a third party pursuant to ORS 656.578.

Should the third party raise formidable affirmative defenses to the worker's cause of action, the worker has several options. She can proceed further, thereby incurring additional litigation costs in an action from which she may not prevail, or seek settlement, and receive a recovery reduced from that which she initially sought. In either scenario, the worker's decision is not without a degree of risk. Yet, we submit that this risk rests squarely with the appropriate party.

As prosecutor of the third party action, the worker is aware of the potential weaknesses of her case, as well as the statutory distribution schemes for any third party recovery. Considering this accessability to vital information, the worker is

in the best position to make an informed and reasoned decision concerning the future of the third party action.

On the other hand, the paying agency is statutorily required to provide compensation benefits to the worker. These claim costs remain constant regardless of the worker's fault or the amount of any third party recovery. Furthermore, as a paying agency, it is entitled to a share of a worker's third party recovery, only after deductions for attorney fees, litigation costs, and the worker's statutory one-third portion. See ORS 656.593(1),(3). Thus, the statutes foresee that the costs of a "risky" litigation are designed to be borne by the prosecutor of the third party action, who is the worker in this case, from the recovery proceeds. It is only after the satisfaction of the aforementioned costs that the worker and the paying agency receive their respective shares of the balance, whatever those amounts may be.

In conclusion, we consider any standard which would inject the element of a worker's fault into the distribution scheme for third party settlements to be contrary to the workers' compensation act in general and the aforementioned statutes in particular. Consequently, we decline to adopt such a standard.

Accordingly, we hold that a distribution of the third party settlement proceeds in accordance with ORS 656.593(1) is "just and proper." Inasmuch as SAIF's third party lien exceeds the remaining balance of settlement proceeds, claimant's attorney is directed to distribute the remainder of the proceeds to the SAIF Corporation.

IT IS SO ORDERED.

LORI L. AASTED, Claimant
Kirkpatrick & Zeitz, Claimant's Attorneys
Roberts, et al., Defense Attorneys

WCB 87-04889
September 18, 1989
Order on Reconsideration

Claimant has requested reconsideration of our August 31, 1989 Order on Review that reversed a Referee's order and upheld the self-insured employer's partial denial of chiropractic treatment for a low back injury in excess of two times per month. Specifically, claimant contends that she is entitled to the carrier-paid attorney fee, as awarded by the Referee, for prevailing against a denial of all chiropractic treatment.

On February 19, 1987, the employer issued a denial of claimant's aggravation claim. It further denied any and all treatment rendered by Dr. Urban, claimant's treating chiropractor, in January 1987 on the basis that his chartnotes indicated that he was treating areas not related to the industrial injury.

On May 27, 1987, the employer issued an addendum to the denial letter of February 19, 1987. This addendum denied all chiropractic treatment directed towards claimant's knees, elbows, shoulders, hips, feet, wrist and neck. It also clarified the February 19, 1987 denial of treatment towards the compensable low back injury by denying such treatments in excess of two times per month.

The Referee's order upheld the May 27, 1987 denial with

the exception of that portion of it that related to chiropractic treatment in excess of two times per month for claimant's low back injury. The Referee's order further awarded claimant's attorney $1,500, for overcoming that portion of the carrier's denial relating to chiropractic treatment for claimant's compensable back injury.

Our August 31, 1989 Order on Review, reversed the Referee's order and upheld the May 27, 1987 amended denial in its entirety.

Claimant contends that she is entitled to an attorney fee for overcoming the February 19, 1987 denial. We disagree.

The February 19, 1987 denial was incorporated by reference into the May 27, 1987 "addendum" denial. However, based upon the parties positions, as recited at hearing, only the May 27, 1987 addendum denial was at issue. That denial effectively withdrew the "across-the-board" denial of Dr. Urban's treatment and substituted a denial of treatment in excess of two times per month for the low back and treatment for noncompensable conditions. The Referee's order partially set the denial aside thereby entitling claimant to an carrier-paid fee at the hearing level. However, our Order on Review reversed the Referee and upheld the May 27, 1987 denial in its entirety. Thus, claimant has not overcome the employer's denial and is not entitled to an carrier-paid attorney fee.

Accordingly, our August 31, 1989 order is abated and withdrawn. On reconsideration, as supplemented herein, we adhere to and republish our August 31, 1989 order. The parties' rights of appeal shall run from the date of this order.

IT IS SO ORDERED.

RICHARD R. BOATSMAN, Claimant
Robert J. Guarrasi, Claimant's Attorney
Kevin L. Mannix, Defense Attorney

WCB 89-03776
September 18, 1989
Order Denying Motion to Dismiss

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

FINDINGS

The Referee's Opinion and Order issued June 23, 1989. On July 8, 1989, claimant, through his attorney, mailed a copy of a request for Board review of the Referee's order to the employer's counsel. The request was accompanied by a cover letter from claimant's counsel, which was addressed to the Chairman of the Board in care of the Salem office. The request, as well as the cover letter, were dated July 8, 1989. It was received on July 10, 1989 by the employer's counsel.

On July 21, 1989, the Board received a request for review of the Referee's order from the employer, through its attorney. The request, which was not mailed by registered or certified mail, indicated that a copy had been provided to claimant and his attorney. On July 26, 1989, the Board mailed a computer-generated letter to the parties acknowledging the request.

If claimant's request for review was delivered to the Board, it was not routed to the file in this case until a copy was submitted by counsel for the employer on August 23, 1989.

Claimant's request for review of the Referee's order was mailed to the Board on July 8, 1989.

ULTIMATE FINDINGS

Claimant's request for review was mailed to the Board within 30 days from the Referee's order.

CONCLUSIONS

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

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

Here, the 30th day after the Referee's June 23, 1989 order was July 23, 1989, a Sunday. Thus, the last day to timely submit a request for Board review of the Referee's order was Monday July 24, 1989. See ORS 174.120. Claimant's request for Board review was mailed by neither registered nor certified mail. Since the request was actually received by the Board on August 23, 1989, which is after the date for timely filing, it is presumed to be untimely until claimant establishes that the mailing was timely. See OAR 438-05-046(1)(b).

In response to the employer's motion to dismiss, claimant has submitted an affidavit from his attorney. Claimant's counsel certifies that he personally prepared claimant's request for review of the Referee's order and mailed the request to the Board on July 8, 1989. This certification, in conjunction with the request and its accompanying cover letter, establishes that claimant's request for review was timely mailed to the Board. Consequently, we conclude that the presumption of untimeliness has been overcome. See OAR 438-05-046(1)(b); Maria Campos, 40 Van Natta 408 (1988).

Accordingly, the motion to dismiss is denied. As a result of our decision, the identification of the parties will be altered as follows. Claimant shall be the appellant and the

employer shall be the respondent. Upon receipt of the hearing transcript, copies will be provided to the parties and a briefing schedule implemented. Claimant's appellant's brief shall be due 14 days from the date of mailing of the transcript. The employer's respondent's / cross-appellant's brief shall be due 14 days from the date of mailing of claimant's brief. Claimant's reply / cross-respondent's brief shall be due 7 days from the date of mailing of the employer's brief. The employer's cross-reply brief shall be due 7 days from the date of mailing of claimant's brief.

IT IS SO ORDERED.

RODGER L. GAINES, Claimant
Quinten Estell, Claimant's Attorney
Richard Barber, Defense Attorney

WCB 87-13833
September 18, 1989
Order on Reconsideration

Claimant requests reconsideration of the Board's August 31, 1989 Order on Review that declined to remand the matter to the Referee for completion of a post-hearing deposition and that affirmed the Referee on the merits. Claimant contends that, with regard to the remand issue, the Board's factual findings and conclusions are either unsupported by the record or otherwise improper.

On reconsideration, we adhere to our prior order with the following supplementation and modification.

First, we make the following finding:

> "Dr. Stanley's January 27, 1988 telephonic deposition was discontinued when it became apparent that he required additional time within which to review his file. Claimant's attorney requested that the deposition be reconvened in person, in part so that he would have the opportunity to review the documents to which Dr. Stanley was testifying."

This finding is in lieu of our prior finding wherein we stated:

> "During the course of that deposition, claimant's attorney suggested that the deposition be reconvened in person at a later date so that claimant's attorney would have an opportunity to review Dr. Stanley's file."

In addition, we noted in our conclusion that the record disclosed no "culpability" on the part of the insurer with regard to the delay in completing Dr. Stanley's deposition. Claimant's counsel is concerned that our conclusion suggests "culpability" on his part. Such is not the case. Claimant had requested the depostion of Dr. Stanley. Had the insurer improperly caused or contributed to the delay in Dr. Stanley's deposition, our decision concerning remand may have been different. In any event, our conclusion was directed solely to an examination of the insurer's conduct and should not be read so as to suggest that claimant's counsel was himself "culpable" for the delay.

Accordingly, our August 31, 1989 order is withdrawn. On reconsideration, as supplemented and modified herein, we adhere to and republish our prior order in its entirety. The parties' rights of appeal shall run from the date of this order.

IT IS SO ORDERED.

DAVID L. ISRAEL, Claimant
National Union Fire Ins. Co., Insurance Carrier

Own Motion 89-0493M
September 18, 1989
Denial of Consent to Issuance of Order Designating a Paying Agent (ORS 656.307)

The Compliance Division has received a request for a pro rata distribution of temporary total disability payments between the aforementioned 1978 knee injury claim and a separate claim for a 1988 hand injury. See OAR 436-60-020(2). Claimant's aggravation rights on the 1978 claim have expired, and that claim is subject to ORS 656.278. Compliance has requested that the Board determine if it will reopen the 1978 claim and/or consent to designation of a paying agent under OAR 438-12-032(3).

The compensation at issue here was paid under the 1978 injury claim pursuant to the self-insured employer's voluntary reopening of that claim. See ORS 656.278 (4); OAR 438-12-025(3). The employer reclosed the claim on July 13, 1989, and claimant has not requested Board review of that closure. See OAR 438-12-055 and 438-12-060. Nor has the employer requested reimbursement from the Reopened Claims Reserve. See 438-12-052.

We conclude that consent to designation of a paying agent under OAR 438-12-032 is not necessary in this situation. We further conclude that no other exercise of own motion authority is required at the present time. Compliance is free to proceed with the requested pro rate distribution.

IT IS SO ORDERED.

JOHN L. KATZENBACH, Claimant
Robert L. Chapman, Claimant's Attorney
Cowling & Heysell, Defense Attorneys

WCB 85-14924
September 18, 1989
Order on Remand

This case is on remand from the Supreme Court. Boise Cascade Corporation v. Katzenbach, 307 Or 391 (1989). The Court reversed and remanded our prior order that reversed the Referee's order upholding the self-insured employer's denial of current medical services for a right wrist condition. In doing so, the Court instructed that we address the merits of claimant's claim under Bauman v. SAIF, 295 Or 788 (1983); Johnson v. Spectra Physics, 303 Or 49 (1987); and Georgia Pacific v. Piwowar, 305 Or 494 (1988). We proceed to do so.

For reasons different from those stated in our prior order, we continue to conclude that the Referee's order should be reversed and the employer's partial denial set aside.

ISSUES

1. Whether the employer's acceptance of claimant's industrial injury claim for a right wrist strain, included acceptance of a condition later diagnosed as avascular necrosis.

2. Whether claimant's compensable right wrist injury was a material contributing cause of the avascular necrosis condition and resulting need for medical services.

FINDINGS OF FACT

The Board adopts the Referee's findings with the following supplementation.

The "801" claim form provides that claimant sustained a "right [w]rist strain" on June 11, 1985. The employer officially accepted the claim as an "injury" on June 18, 1985. Subsequently, after issuing a partial denial on November 15, 1985, the insurer amended the claim form by checking the box labeled "denied" accompanied by the handwritten date "11-15-85."

Claimant suffers from a congenital ulnar minus condition, which predisposed him to developing avascular necrosis.

A right wrist strain is a separate condition from that of avascular necrosis.

FINDINGS OF ULTIMATE FACT

Claimant's compensable wrist injury is a material contributing cause of his avascular necrosis condition and need for medical services.

CONCLUSIONS OF LAW

"Back-up" Denial

An employer may not "back-up" and deny a previously accepted condition, absent fraud, misrepresentation or other illegal activity. Bauman, 295 at 794. An employer's acceptance of a claim includes only those conditions specifically accepted in writing. Johnson, 303 Or at 55. Read together, Bauman and Johnson require an employer to compensate the worker "for the specific condition in the notice of acceptance regardless of the cause of that condition." Piwowar, 305 Or at 501.

As we understand the above cases, the rule in Bauman must be interpreted in the light of Johnson and Piwowar. The latter two cases address what "condition" was initially accepted, which must be determined before the trier of fact can ascertain whether a previously accepted claim has been retroactively denied in violation of the Bauman rule.

Here, the employer initially merely checked-the-box labeled "accepted" on the claim form. (Ex. 1). Had the employer stopped there, we would have had little difficulty in concluding that, like the case in Johnson, it had not specifically accepted in writing the avascular necrosis condition. However, the employer did not do that. After it issued its partial denial, dated November 15, 1985, it amended the claim form by checking-the-box labeled "denied" accompanied by the date "11-15-85." The implication of such action, is that employer itself viewed its "partial" denial as a complete denial of claimant's accepted claim. If so, it should not be heard to now defend a claim for an impermissible "back-up" denial, on the basis that it issued only a partial denial.

Nonetheless, absent a specific written acceptance of the condition at issue, we are reluctant to conclude that pursuant to Johnson, the employer initially accepted the condition of avascular necrosis. Therefore, application of Johnson does not result in a finding that the employer issued an impermissible "back-up" denial.

A more difficult matter is whether the employer issued an impermissible "back-up" denial under the dictates of Piwowar. In Piwowar, the worker suffered a low back "strain." On the "801" form, the worker described her injury as a "sore back." Later, evidence revealed that the worker's injury may have arisen from a condition known as "ankylosing spondylitis," which was unrelated to her employment and therefore not compensable. 305 Or 497. Although Piwowar held that the employer had accepted the ankolylosing spondylitis condition, the Court instructed that it would have reached a different result had the employer, as here, accepted only a "strain." 305 Or 501.

Here, the employer did just that; i.e., it accepted only a "right wrist strain." A "strain" is a separate condition from that of "avascular necrosis." See Taber's Cyclopedic Medic Dictionary, Ed. 15, pgs. 162, 1103, & 1636 (1985). Accordingly, consistent with the Court's reasoning in Piwowar, we conclude that the employer did not unwittingly accept the separate condition of avascular necrosis by its acceptance of a strain.

Compensability

We turn to the merits. The Referee resolved the merits of this case by analyzing whether claimant had, in fact, sustained an injury or trauma to his right wrist on June 11, 1985. We disagree with that approach.

In our view, the issue of whether claimant sustained an "injury" was not before the Referee. That narrow factual question had been finally determined by the insurer's initial acceptance. (Ex. 1). It is beyond dispute that the insurer accepted an "injury" that occurred on "June 11, 1985." Id. If the insurer wished to litigate whether claimant, in fact, sustained an injury, it should have done so. It did not. We will not do indirectly, what the insurer declined to do directly.

In short, we conclude that the rule in Bauman narrowly operates to procedurally bar the insurer from retroactively denying its acceptance of an "injury." Our inquiry does not end there, however. We must proceed to resolve whether the accepted June, 1985, right wrist injury, materially contributed to the causation of claimant's avascular necrosis, or claimant's current need for medical treatment for his avascular necrosis condition.

In November, 1985, Dr. Grant, M.D., reported that without a history of a "traumatic incident or abrupt onset of pain with any specific activity it's hard to pinpoint the etiology of [claimant's] lesion." (Exs. 7 & 13). The implication of Grant's report is that, had claimant sustained an injury, he would have viewed it as the cause of the avascular necrosis condition. Inasmuch as we have found above that claimant sustained an injury, we view Dr. Grant as supporting a finding of compensability. Similarly, Dr. McIntosh testified, that assuming the occurrence of

an injury, there was "a good likelihood" that it would be directly related to the cause of claimant's avascular necrosis.

In the light of the above, we conclude that claimant has proven that the compensable June, 1985, injury materially contributed to the causation and need for medical services for his current avascular necrosis condition.

Claimant's attorney is entitled to an additional assessed fee for services rendered at all forums subsequent to our prior order of November 19, 1987. ORS 656.388(1). However, inasmuch as we have not received a statement of services from claimant's attorney, to date, we are presently unable to award such a fee. OAR 438-15-010(5). For the reasons stated above and not those stated in our prior order, dated November 19, 1987, we adhere to our prior order which set aside the employer's partial denial, awarded attorney fees, and remanded the claim to the employer for further processing.

IT IS SO ORDERED.

LEROY R. FOWLER, Claimant

Own Motion 89-0410M
September 20, 1989
Own Motion Order

The self-insured employer has submitted to the Board claimant's claim for an alleged worsening of his April 12, 1982 injury to his right knee. Claimant's aggravation rights have expired. The self-insured employer has accepted responsibility for the right knee condition and related surgery, and it recommends that claimant's claim be reopened for payment of temporary disability benefits.

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

Following our review of this record, we are persuaded that claimant's compensable right knee injury has worsened requiring surgery. Accordingly, his claim is reopened for temporary disability compensation to commence April 21, 1989, the date he was hospitalized for right knee surgery, and to continue until his right knee condition becomes medically stationary or he returns to regular work at his regular wage, 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 1982 injury claim should be closed by the insurer pursuant to OAR 438-12-055.

Pursuant to our Own Motion Order, issued January 18, 1989, claimant may be receiving temporary disability compensation for a separate 1979 left knee injury with the employer. (WCB Case No. 89-0137M). Claimant is not entitled to receive double the statutory sum for the same period of time loss because he has two separate disabling injuries. Fischer v. SAIF, 76 Or App 656, 661

(1985); Petshow v. Portland Bottling Co., 62 Or App 614 (1983), rev den 296 Or 350 (1984). The employer is free to petition the Compliance Division for a pro rata distribution of payments between the two claims. See OAR 436-60-020(2).

IT IS SO ORDERED.

GINA J. GARRETY, Claimant
Yacob & Associates, Claimant's Attorneys
SAIF Corp Legal, Defense Attorney

WCB 87-09789
September 20, 1989
Order on Review

Reviewed by Crider and Perry.

The SAIF Corporation requests review of those portions of Referee Heitkemper's order that: (1) declined to consider Exhibits 1 and 11; and (2) awarded claimant additional temporary disability compensation. On review, the issues are evidentiary and temporary disability.

The Board reverses on the evidentiary issue, but affirms on the issue of temporary disability.

FINDINGS OF FACT

Evidentiary Issue

Exhibits 1 and 11 were admitted into evidence without objection. Exhibit 1 consists of three pages of chart notes from claimant's former treating physician, Dr. Utterback. Exs. 1, 3, & 6. Exhibit 11 is a chart note from claimant's current treating physician, Dr. Waldram. Exs. 10 & 11.

Temporary Disability

The Board adopts the Referee's findings of fact with the following supplementation.

On June 10, 1986, claimant's then treating physician, Dr. Utterback, released her to return to regular work without restrictions. Claimant was not, however, medically stationary at that time. Claimant did not become medically stationary until after October 3, 1986.

CONCLUSIONS OF LAW

Evidentiary Issue

The Referee admitted Exhibits 1 and 11, but chose to "ignore" such evidence in deciding this case because he found it "impossible" to ascertain authors of those exhibits. We disagree with the Referee's failure to consider Exhibits 1 and 11 in resolving this case.

As a matter of procedure, we disagree with the practice of admitting certain documents and then ignoring them when weighing the evidence. As a fact finder, a Referee is not at liberty to ignore certain portions of the record. The remedy for non-admissible documents, is an objection. Here, Exhibits 1 and 11 were admitted without objection. Accordingly, the Referee should have considered those exhibits in deciding this case.

Furthermore, a referee is not bound by common law or statutory rules of evidence and may conduct the hearing in any manner that will achieve "substantial justice." ORS 656.283(7). Here, Exhibits 1 and 11 are germane to the issue of when claimant was both released to regular work and became medically stationary. See Fazzolari v United Beer Distributors, 91 Or App 592 on recon 93 Or App 103 rev den 307 Or 236 (1988). We agree, therefore, with the Referee's admission of those exhibits. However, after reviewing the record, we have found that Exhibit 1 was authored by Dr. Utterback, and Exhibit 11 by Dr. Waldram. We, therefore, disagree with the Referee's finding that it is "impossible" to ascertain the authors of those exhibits.

Accordingly, we have considered Exhibits 1 and 11 in conducting our de novo review of this case.

Temporary Disability

We adopt the Referee's opinion on the issue of claimant's entitlement to temporary disability benefits from June 10, 1986, through October 3, 1986, with the following supplementation. After the Referee's order issued, the Court of Appeals rendered its decision in Fazzolari, supra. The Fazzolari court announced that an insurer must continue to pay temporary disability compensation, unless the worker is both released to regular work and medically stationary. 91 Or App at 595.

Here, claimant was not medically stationary on June 10, 1986, or at any time prior to October 3, 1986. Although Dr. Utterback released her to return to regular work on June 10, 1986, see Ex. 1-2, he also stated, inter alia: "[Claimant] states that she is going to Montana in just a few days to be with her husband and was advised to continue her exercise program and recheck with an orthopedist there if she gets into trouble." Several weeks later, on July 29, 1986, Utterback could only speculate as to whether claimant was medically stationary because he had not seen her since his examination of June 10, 1986. However, on July 23, 1986, claimant was examined by Dr. Hunter, M.D., for continued problems with her left knee. Hunter treated with anti-inflammatories and scheduled a followup examination. Eventually, Hunter diagnosed a torn medial meniscus and performed corrective surgery on October 6, 1986.

In sum, for the reasons stated above, we agree with the Referee's conclusion that claimant was entitled to continued temporary disability benefits from June 10, 1986, through October 3, 1986. Claimant's counsel has submitted a statement of services, seeking an attorney fee for prevailing against SAIF's appeal. However, claimant's brief was rejected as untimely. Under such circumstances, claimant is not entitled to an attorney fee. Shirley M. Brown, 40 Van Natta 879 (1988).

ORDER

The Referee's order, dated March 23, 1988, is reversed in part and affirmed in part. That portion of the order that declined to consider Exhibits 1 and 11, is reversed. All remaining portions of the order are affirmed.

KARL MITCHELL, Claimant
Pozzi, et al., Claimant's Attorneys

Own Motion 86-0064M
September 20, 1989
Own Motion Order Reviewing Self-Closure

Claimant appeals the insurer's January 31, 1989, Notice of Closure, whereby temporary disability benefits were terminated as of December 28, 1988.

The Board reopened this claim under ORS 656.278 by Own Motion Order dated June 30, 1987. Therefore, this claim must be closed by the Board under the law and rules in effect on the date the claim was ordered reopened. OAR 438-12-018. Unlike the current own motion law, the law and rules in effect on June 30, 1987, did not permit insurers to close claims without the issuance of a Board order. See former ORS 656.278; OAR 438-12-005 et seq. Consequently, the insurer's self-closure of this claim was impermissible. Accordingly, the Notice of Closure is set aside. The record presently does not include any persuasive medical evidence that claimant is medically stationary. Therefore, claim closure is not proper at this time. Claimant's claim is remanded to the insurer for further processing according to law.

IT IS SO ORDERED.

SARA I. SWARTWOUT, Claimant
Peter O. Hansen, Claimant's Attorney

Own Motion 88-0426M
September 20, 1989
Own Motion Order of Enforcement

Claimant requests that the Board enforce its August 2, 1988 Own Motion Order. That order reopened claimant's 1976 injury claim for additional temporary total disability compensation. The insurer had accepted responsibility for claimant's condition and recommended that her 1976 injury claim be reopened for temporary total disability compensation.

After the August 2, 1988 Own Motion Order issued, the Board received a letter from claimant's attorney requesting remand of the own motion matter to the Hearings Division to determine whether claimant's current condition was related to her 1976 injury or a new incident with the same employer. Claimant also requested a hearing on the insurer's "de facto" denial of her current condition as a new injury or occupational disease. (WCB Case No. 88-13412).

The Board then issued a Second Own Motion Order, dated September 10, 1988, that denied claimant's request for remand, left the August 2, 1988 Own Motion Order in place, and instructed the insurer to request termination of that order if claimant prevailed in the pending litigation. That order was later withdrawn and republished, effective September 16, 1988. The pending litigation proceeded to hearing, and the Referee's Opinion and Order is currently pending Board review.

The temporary disability compensation rate for the 1976 injury is higher than the rate payable for a new injury or occupational disease. Although the insurer commenced payment of temporary disability benefits, it did so at the lower rate associated with a new injury or occupational disease. Claimant now asks the Board to order the insurer to pay the higher rate of compensation, along with a penalty and associated attorney fee.

After review of the record, we conclude that the Board's August 2, 1988 order remains in force. The Board has neither withdrawn or abated that order, and it has not been reversed on appeal. As a result, the insurer was clearly obligated to pay the higher temporary disability compensation rate awarded under the August 2, 1988 order. Furthermore, the insurer has not demonstrated that it had good cause for its failure to pay the higher rate of compensation. We, therefore, conclude that it unreasonably resisted payment of the compensation awarded under the Board's August 2, 1988 order.

Accordingly, the insurer is instructed to commence payment of temporary disability compensation at the higher rate associated with the 1976 injury. The insurer is also instructed to pay claimant the differential between past payments of temporary disability compensation at the lower rate and compensation due under the higher rate. Finally, we assess a penalty equal to 25 percent of the overdue compensation, and an associated attorney fee in the amount of $300.

IT IS SO ORDERED.

GLENN L. WOODRASKA, Claimant
Kevin L. Mannix, Defense Attorney

WCB 88-11218 & 86-16658
September 20, 1989
Order on Review (Remanding)

This is a consolidated review of WCB Case Nos. 86-16658 and 88-11218. In WCB Case No. 86-16658, claimant requests review of Referee Mongrain's order that dismissed his hearing request for abandonment. Additionally, the insurer apparently contends that the Referee erred in declining to consider its request for hearing on its own denial. In WCB Case No. 88-11218, claimant requests review of Referee Neal's order that dismissed his hearing request for lack of jurisdiction. We affirm in WCB Case No. 86-16658 and reverse in WCB Case No. 88-11218.

ISSUES

WCB Case No. 86-16658

1. Board Review. Whether claimant's opening brief on Board review was untimely.
2. Dismissal. Whether the Referee properly dismissed claimant's hearing request for abandonment.
3. Dismissal. Whether the dismissal order was issued "with prejudice."
4. Request For Hearing. Whether the Referee properly declined to consider the insurer's March 2, 1988, denial.

WCB Case No. 88-11218

Dismissal/Jurisdiction. Whether the Referee properly dismissed claimant's hearing request for lack of jurisdiction.

FINDINGS OF FACT

WCB Case No. 86-16658

Claimant compensably injured his low back in July, 1985. Sometime after the injury, claimant apparently moved to Arizona. His claim for that injury was accepted and later closed

by Determination Order on October 22, 1986, with 15 percent unscheduled permanent disability. Claimant retained counsel and timely requested a hearing regarding that order. An expedited hearing was set for late January, 1987. Due to surgery in early January, however, claimant's case was placed in inactive status until November, 1987.

Meanwhile, claimant's claim had been reopened for an aggravation of his injury. The claim was closed by Determination Order on August 20, 1987, with an additional 5 percent unscheduled permanent disability.

Claimant retained a new attorney and in August, 1987, filed a second request for hearing on the October 22, 1986, Determination Order. A hearing was set for late December, 1987. Two weeks before the scheduled hearing, claimant requested that the case again be placed in inactive status due to continued treatment and inability to travel from Arizona. The request was granted.

In late January, 1988, claimant filed a supplemental request for hearing on the August 20, 1987, Determination Order. A hearing was set for early March, 1988. Before the scheduled hearing, however, claimant dismissed his attorney from the case. In his withdrawal letter, the attorney requested on claimant's behalf that the hearing be postponed. The hearing was reset for April 18, 1988.

On March 2, 1988, the insurer issued a partial denial of claimant's medical services claim relating to particular degenerative conditions in the low back. In the same denial letter, the insurer also denied any asserted claim for aggravation. Seven days later, on March 9, 1988, the insurer filed a request for hearing on its denial letter. In that request, the insurer asked that its hearing request be consolidated with claimant's pending hearing requests and that the partial denial be considered at the scheduled hearing on April 18, 1988. At hearing, the insurer asked that its denial be upheld.

On March 10, 1988, Referee Mongrain received a letter from claimant stating that he could not travel to Oregon for the scheduled hearing due to his physical and financial conditions. Viewing the letter as a motion for postponement, the Referee denied the motion, but advised claimant that he would reconsider the motion if, within two weeks of the scheduled hearing, claimant provided medical verification from his treating physician that he is unable to travel due to his physical condition. Claimant did not respond.

At hearing on April 18, 1988, claimant was neither present nor represented by counsel. On the insurer's motion, the Referee dismissed claimant's request for hearing on the Determination Orders of 1986 and 1987 for abandonment. Although the Referee stated at hearing that claimant's hearing request would be dismissed "with prejudice," his dismissal order does not indicate whether or not it was dismissed with prejudice. Additionally, the Referee declined to consider the March 2, 1988, denial, apparently reasoning that any hearing on the denial would be premature so long as claimant had additional time to appeal the denial. Claimant requested Board review of the Referee's order.

WCB Case No. 88-11218

On July 5, 1988, claimant filed a request for hearing on the August 20, 1987, Determination Order and the March 2, 1988, denial. The insurer moved for dismissal of the hearing request on timeliness and jurisdictional grounds. Regarding jurisdiction, the insurer contended that the dismissal order in WCB Case No. 86-16658 precluded litigation of issues relating to the Determination Order and the denial. The Referee granted the motion to dismiss on jurisdictional grounds, reasoning that, by virtue of the pending Board review request in WCB Case No. 86-16658, the Board had exclusive subject-matter jurisdiction of the issues raised by this hearing request. Claimant's hearing request was dismissed without prejudice. Claimant requested Board review of the Referee's order and consolidation of this appeal with his pending review request in WCB Case No. 86-16658. The Board granted the motion to consolidate.

FINDINGS OF ULTIMATE FACT

WCB Case No. 86-16658

1. Claimant's opening brief on Board review was not filed within 14 days from the mailing of the transcript.

2. Claimant failed to appear at the April 18, 1988, hearing. We do not find that there were extraordinary circumstances to warrant postponement of the hearing.

3. The Referee's dismissal order of April 21, 1988, was issued without prejudice.

4. The insurer's request for hearing on its March 2, 1988, did not seek a change in the status quo or otherwise create a controversy.

WCB Case No. 88-11218

The dismissal order in WCB Case 86-16658 was not a final judgment on issues raised in claimant's hearing request of June 30, 1988.

CONCLUSIONS OF LAW AND OPINION

WCB Case No. 86-16658

1. Whether claimant's brief should be stricken as untimely.

Preliminarily, we address the insurer's contention that claimant's opening brief should be stricken as untimely filed. The party requesting Board review must file the appellant's brief to the Board within 14 days after the date of mailing of the transcript of record to the parties. OAR 438-11-020(2). Here, the transcript of record was mailed to the parties on October 18, 1988, giving claimant until November 1, 1988, in which to file his appellant's brief. However, the appellant's brief was received by the Board on November 3, 1988, without any proof that mailing was accomplished by November 1. We find, therefore, that claimant's opening brief was not timely filed. OAR 438-05-046(1)(c). Accordingly, the brief shall not be considered on Board review. See, e.g., Pedro G. Alcala, 39 Van Natta 450 (1987).

The insurer further contends that a copy of a

handwritten letter from claimant, which is attached to the appellant's brief, likewise should not be considered because it was not admitted into the record at hearing. We disagree. The disputed letter was admitted into evidence at hearing in WCB Case No. 88-11218. Marked as Exhibit 41A, the letter was admitted for the limited purpose of showing claimant's state of mind. Because WCB Case No. 88-11218 is now consolidated with this case on Board review, we may consider the record in that case in our review. Hence, it is proper to consider Exhibit 41A insofar as it goes to claimant's state of mind.

2. Whether the Referee properly dismissed claimant's hearing request.

Under the applicable Board rules, the failure of claimant or his representative to appear at hearing on April 18, 1988, amounted to a waiver of appearance. See former OAR 438-06-071 (WCB Admin. Order 5-1987, effective January 1, 1988). Because claimant requested the hearing, the Referee had to dismiss the hearing request for failure to appear unless a postponement was granted under former OAR 438-06-081. See id. A scheduled hearing cannot be postponed under OAR 438-06-081 except upon a finding of "extraordinary circumstances" beyond the control of the party requesting postponement.

Claimant moved for postponement of the hearing on the basis that he could not travel to Oregon due to his financial and physical conditions. However, claimant's inability to afford the cost of attending the hearing did not constitute an "extraordinary circumstance." The cost of attending a hearing, along with other litigation expenses, generally is borne by the parties. Claimant requested a hearing which presumably was set in the county where he resided at the time of injury. See ORS 656.283(5). Sometime after his injury, claimant moved to Arizona of his own volition. Consequently, claimant must bear the costs of returning to Oregon to prosecute his claim.

We also are not persuaded that claimant's physical condition constituted an "extraordinary circumstance." The Referee gave claimant until two weeks prior to the hearing in which to submit medical verification of his inability to attend the hearing. Claimant failed to do so, despite the fact that he was receiving medical care in Arizona and, therefore, had ample opportunity to obtain such verification. Without medical verification, we do not find that claimant was physically unable to attend the hearing. Other factors weighing against postponement was the 15-month delay since the first hearing was scheduled at claimant's request and the three previous postponements that were granted at claimant's request. Under those circumstances, the Referee properly denied the motion to postpone the hearing. See OAR 438-06-081. Because a postponement was not appropriate, the Referee properly dismissed claimant's hearing request. See OAR 438-06-071.

3. Whether claimant's hearing request was dismissed with prejudice.

The next issue is whether this Referee dismissed claimant's hearing request "with prejudice." If so, claimant would be barred from subsequently relitigating any claims asserted or issues raised in that hearing request.

It is our policy to interpret any dismissal order issued by the Hearings Division as an order of "dismissal without prejudice," unless the order states otherwise. Robert L. Murphy, 40 Van Natta 442 (1988). Here, although the Referee stated at hearing that he would dismiss claimant's hearing request "with prejudice," there is no mention of "prejudice" in the dismissal order itself. Moreover, the dismissal order expressly incorporates the Referee's discussion at hearing only insofar as it addressed his reasons for concluding that claimant abandoned his hearing request. The order did not appear to incorporate any discussion of "prejudice." Absent any reference to "prejudice" in the dismissal order, we interpret the order as a dismissal without prejudice. See id. Consequently, the dismissal order does not have any preclusive effect on subsequent litigation.

4. Whether the Referee properly declined to consider the insurer's request for hearing on its partial denial. The insurer requested a hearing on its own denial requesting that the referee affirm the denial by order.

The Referee stated at hearing that he would not consider the insurer's March 2, 1988, denial, apparently reasoning that a hearing on the denial would be premature so long as claimant had additional time for appealing the denial. Tr. 12. However, the Referee's order neither discusses the denial nor makes any disposition of the insurer's hearing request from the denial. The insurer now asks the Board to uphold its denial on the merits. We decline to do so for lack of jurisdiction.

The insurer contends that it properly invoked the jurisdiction of the Hearings Division to consider the merits of its denial. We disagree. ORS 656.283(1) provides in relevant part: "Subject to ... ORS 656.319, any party ... may at any time request a hearing on any question concerning a claim."

Implicit in the statute is the proposition that a "question concerning a claim" involves a controversy in which the party requesting a hearing seeks to change the status quo. Thus, while an employer may request a hearing to alter a decision of a government entity or to obtain authorization to do something that the statute does not permit it to do unilaterally, an employer may not request a hearing either to challenge or to seek vindication of its own conduct. Therefore, although both employers and workers may request a hearing seeking to change a determination order, only workers may seek a hearing concerning a denial of claim.

Our view in this respect is fortified by the fact that ORS 656.319(1), to which ORS 656.283 is expressly subject, establishes the time during which claimant may request a hearing concerning a denial but makes no reference to employer requests for hearing concerning denials. See also, ORS 656.262(8), which also governs worker requests for hearing on a denial.

Here the insurer requested a hearing in order to force the compensability issue to hearing along with the issues already set for hearing. Because the insurer did not seek to change the status quo, there was no controversy and thus no "question concerning a claim." As the Hearings Division has jurisdiction

only of questions concerning a claim, the insurer's hearing request should have been dismissed for lack of jurisdiction.*

WCB Case No. 88-11218

The sole issue in this case is whether the Referee properly had jurisdiction of claimant's request for hearing on the August 20, 1987, Determination Order and the March 2, 1988, denial. The Referee concluded that she did not and dismissed the hearing request without prejudice, reasoning that those issues were before the Board on appeal in WCB Case No. 86-16658 and, therefore, were within the Board's exclusive jurisdiction. We disagree and, therefore, reinstate claimant's hearing request.

In WCB Case No. 86-16658, we found that the Referee's dismissal order was issued without prejudice and that the Hearings Division was without jurisdiction to consider the insurer's request for hearing on its March 2, 1988 denial. Given those findings, the order in that case did not bar subsequent litigation of issues raised by claimant's July, 1988, hearing request. Accordingly, this Referee's dismissal order is reversed and claimant's July, 1988, hearing request is reinstated.

We may either review the merits of this case de novo, see ORS 656.295(6), or we may remand the case to the Referee for further proceedings if we determine that it has been improperly, incompletely or otherwise insufficiently developed or heard by the Referee. See ORS 656.295(5). Following our review of the record, we find that this case was insufficiently developed and heard by the Referee. Therefore, the case is remanded to the Referee for further action consistent with this order.

ORDER

In WCB Case No. 86-16658, the Referee's dismissal order dated April 21, 1988, is affirmed. In that case, the Board approves a client-paid fee not to exceed $1,000. In WCB Case No. 88-11218, the Referee's dismissal order dated November 17, 1988, is reversed. Claimant's hearing request dated June 30, 1988, is reinstated, and the case is remanded to Referee Neal with instructions to schedule a hearing concerning the issues raised in claimant's request. In that case, the Board approves a client-paid fee not to exceed $700.

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* Even if the insurer's request vested jurisdiction in the Hearings Division, the insurer had no standing to raise the issue. Cf.,Elmer W. Baird, 34 Van Natta 965 (1982).

The insurer requests review of those portions of Referee Mulder's order that: (1) found that he had jurisdiction to consider claimant's hearing request regarding claim for a right knee and low back condition; and (2) set aside the insurer's partial denial of that claim. Claimant also requests review of Referee Shebley's determination that the insurer was not obligated to pay temporary disability compensation pending Board review of Referee Mulder's order. These cases have been consolidated for purposes of review. On review, the issues are:

- Whether Referee Mulder exceeded his jurisdiction in ruling on the compensability of claimant's current right knee and back conditions.

- If not, whether litigation of the compensability of those conditions is barred under the doctrine of "res judicata".

- If not, whether claimant's current right knee and low back conditions are materially related to his compensable work injuries with the employer.

- Whether Referee Mulder's order awarded temporary disability compensation in regard to claimant's current right knee and back conditions.

- If Referee Mulder's order did award temporary disability compensation:

  o whether that award was beyond his jurisdiction;

  o whether the insurer was obligated to pay temporary disability compensation pending Board review of Referee Mulder's order; and

  o whether claimant is entitled to a penalty and attorney fee for the insurer's failure to pay temporary disability compensation pending Board review.

We affirm the Referees' orders.

FINDINGS OF FACT

Claimant began working for the employer in September 1974. At that time, he had a history of right and left knee contusions and mid and low back strain attributable to a car accident in 1970. He reinjured his left knee in a fall at work on July 21, 1975.

One year later, on July 8, 1976, claimant reinjured both knees in a work-related motor vehicle accident. At that time, he experienced bilateral knee pain when he forcibly smashed both knees against the dashboard of the vehicle he was driving. The insurer ultimately accepted responsibility for this accident as a new injury. Claimant received treatment for his left knee from

Dr. Kiest, orthopedist. His right knee pain resolved without treatment or disability, but returned in early 1977. Medical services at that time were limited to x-rays demonstrating a normal right knee.

Claimant sustained another fall at work in September 1978, reinjuring his right and left knees. The following month, he sustained a nondisabling low back strain. The insurer accepted his claims for new injuries to his knees and low back. Dr. Kiest prescribed pain medication for claimant's knee injury, and claimant received chiropractic treatment for his back strain through February 1979. By that time, his back pain had resolved, but his knees remained problematic.

Sometime prior to May 1979, claimant began performing lighter work for a different employer. He bumped his right knee at work in October 1980, and his new employer accepted his claim for a new, nondisabling injury. Medical services at that time were limited to x-rays demonstrating a normal right knee. Claimant continued to suffer from bilateral knee pain. He also experienced an off-work exacerbation of low back pain in the fall of 1985. His condition at that time was diagnosed as chronic lumbo-sacral sprain/strain. He was taken off work for three weeks and received chiropractic treatment through January 1986.

Meanwhile, claimant sought further treatment for his left knee, and in February 1986 Dr. Kiest recommended arthroscopic surgery on that knee. By that time, aggravation rights had expired on claimant's 1975, 1976 and 1978 injuries with the insurer. In March 1986, claimant requested own motion reopening of his 1975 injury claim for further temporary disability benefits for his left knee condition. While that request was pending, claimant experienced an exacerbation of right knee pain. X-rays taken in April 1986 demonstrated early narrowing and notching of the joint space in the right knee. On April 4, 1986, Dr. Kiest released claimant from work and recommended arthroscopic surgery for both the right and left knees.

An Own Motion Order, issued May 16, 1986, reopened the 1975 injury claim and awarded additional temporary total disability compensation commencing April 4, 1986. The insurer took the position that the Own Motion Order reopened the 1975 claim for the left knee condition, only. Claimant wrote the Board requesting a ruling that the May 16, 1986 Own Motion Order had reopened claimant's 1975 claim for both the right and left knee conditions. That request is now pending before the Board under its own motion authority. (WCB Case No. 86-0226M).

On June 2, 1986, the insurer issued a partial denial of claimant's right knee and back conditions, contending that they were not causally related to his compensable work injuries with the employer. A hearing was held on that denial before Referee Mulder. (WCB Case No. 86-08009). By Opinion and Order, issued March 16, 1987, Referee Mulder concluded that claimant's right knee and back conditions were compensable. The insurer requested reconsideration of Referee Mulder's order, challenging his jurisdiction in this matter. By order issued April 10, 1987, Referee Mulder reissued his March 16, 1987 order.

The insurer then requested Board review of Referee Mulder's order. By Interim Order on Remand, issued March 24,

1988, the Board remanded the case to the Referee for inclusion of missing exhibits. By Order on Remand, issued April 28, 1988, Referee Mulder included the missing exhibits and returned the case to the Board with no change in his decision.

In November 1988, claimant requested an enforcement hearing, seeking payment of temporary disability benefits allegedly due under Referee Mulder's March 16, 1987 order, reissued April 10, 1987. (WCB Case No. 88-20410). The enforcement hearing was held before Referee Shebley. By Opinion and Order issued February 23, 1989, Referee Shebley concluded that the insurer was under no obligation to pay temporary disability compensation pending review of Referee Mulder's order. Claimant requested Board review of Referee Shebley's order.

The aforementioned orders of Referees Mulder and Shebley are before the Board in the present case. We have consolidated our review of these orders with claimant's request for clarification of our May 16, 1986 Own Motion Order in WCB Case No. 86-0226M. We have this day issued our order in that own motion matter.

FINDINGS OF ULTIMATE FACT

The only "claim" addressed in the Board's May 16, 1986 Own Motion Order was for temporary total disability compensation for claimant's left knee condition.

The Board's May 16, 1986 Own Motion Order made no determination regarding compensability of claimant's right knee and back conditions.

Claimant's current right knee condition is materially related to his compensable injury in July 1976.

Claimant's current low back condition is materially related to his compensable injuries in 1975, 1976 and 1978.

Referee Mulder's March 16, 1987 order, as reissued April 10, 1987, made no award of temporary disability compensation.

CONCLUSIONS OF LAW AND OPINION

Compensability Issues

Referee Mulder concluded that claimant's right knee and low back conditions were materially related to his compensable injuries with the insurer. On review, the insurer first contends that this ruling was beyond the Referee's jurisdiction because the 1975 injury claim is currently in own motion status. In the alternative, it argues that litigation of the compensability of claimant's right knee and low back conditions is barred under the doctrine of "res judicata". Finally, the insurer challenges the merits of the Referee's ruling.

We first consider the insurer's jurisdictional challenge. The Hearings Division is a proper forum for litigating compensability issues related to post-1965 injuries. See ORS 656.245 and 656.273. The Board will not exercise its own motion authority where the claimant has another avenue of relief.

See Melvin L. Martin, 37 Van Natta 1119 (1985). Accordingly, Referee Mulder had jurisdiction over the compensability issues in this case, notwithstanding the own motion status of the claim.

We turn to the insurer's "res judicata" argument. The insurer argues that the Board's May 1986 order reopened claimant's claim for his accepted left knee condition, only. It contends that an adverse compensability determination regarding claimant's right knee and back conditions is implicit in the Board's failure to also reopen the claim for these conditions. Accordingly, it argues that this adverse compensability determination precludes relitigation of that issue in the present case. We disagree.

The doctrine of res judicata precludes relitigation of claims and issues previously adjudicated. North Clackamas School District v. White, 305 Or 48, 50, modified, 305 Or 468 (1988). Under the res judicata doctrine of "claim preclusion", litigating a claim or cause of action to final judgment precludes a subsequent action between the same parties on the same claim or any part thereof. Carr v. Allied Plating Co., 81 Or App 306, 309 (1986); Restatement (Second) of Judgments, Sections 17-19, 24 (1982). Under the doctrine of "issue preclusion", 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. North Clackamas School District v. White, supra at 53.

As a preliminary matter, we conclude that the present case involves "issue preclusion", rather than "claim preclusion". We are persuaded that the only "claim" addressed in the Board's May 1986 order was for temporary total disability compensation for claimant's left knee condition. As the present case involves claims for right knee and back conditions, the doctrine of "claim preclusion" is not applicable.

In reaching this decision, we recognize that the Board's May 1986 order is somewhat ambiguous as to the "claim" it is addressing. The Board ultimately ordered the insurer to pay temporary disability compensation from the date the treating physician "took claimant off work due to his knee condition". It is not entirely clear from this language whether the Board was referring to claimant's left knee condition, or to his bilateral knee problems.

Furthermore, references to claimant's right knee and back condition throughout the order suggest that the Board may have been considering reopening for these problems. For example, the Board's order includes the following findings: that claimant's treating physician had recommended claimant be on time loss compensation for both right and left knee difficulties, that an arthroscopy was recommended in order to determine claimant's status with respect to his "knees"; that the treating physician's April 4, 1986 report was the first medical evidence clearly indicating a material worsening of claimant's knee "conditions"; and that claimant was off work prior to that date due to a back condition.

However, unlike the accepted left knee condition, claimant's right knee and back conditions had not been accepted by the insurer. As a result, reopening the claim for those conditions would have required the Board to make a compensability

determination. As previously discussed, the Hearings Division had jurisdiction over the compensability issues in this case, and the Board does not exercise its own motion authority when the claimant has another avenue of redress. Accordingly, we conclude that the Board's order only addressed a claim for additional temporary disability benefits for the accepted left knee condition.

We proceed to the possible application of the res judicata doctrine of "issue preclusion". The insurer contends that the Board's May 1986 Own Motion Order implicitly determined that his right knee and back conditions were not related to the compensable injury. We have previously determined that the Board's order did not address the relationship between these conditions, and the compensable injury either directly or implicitly, because relief was available through the Hearings Division. Furthermore, the "implicit" determination alleged by the insurer is not the type of clear finding of fact required for the application of the doctrine of issue preclusion. See Chavez v. Boise Cascade Corporation, 307 Or 632, 637-638 (1989).

Moreover, assuming the Board had implicitly determined that claimant's right knee and back conditions were not related to the compensable injury, that determination was not essential to the Board's decision to reopen his claim for additional temporary disability benefits for his left knee condition. Accordingly, we conclude that the doctrine of "issue preclusion" does not bar litigation of the compensability issues in this case.

Finally, we review the merits of Referee Mulder's compensability ruling. The Referee concluded that claimant's right knee condition is materially related to his compensable bilateral knee injury in July 1976. Referee Mulder also determined that claimant's low back condition is materially related to his compensable injuries in 1975, 1976 and 1978.

We affirm Referee Mulder's rulings regarding both conditions. In regard to claimant's low back problem, we note that treating orthopedic surgeon Kiest and treating chiropractor Ulbrich both opined that claimant's bilateral knee problems resulted in an altered gait which contributed to his current low back complaints. Although the Western Medical Consultant's disagreed, their opinion is conclusory. We, therefore, defer to the opinions of the treating physicians.

In deferring to their opinions, we recognize that Drs. Kiest and Ulbrich were not apprised of claimant's car accident in 1970, or his right knee injury with a different employer in October 1980. However, we are not persuaded that the persuasiveness of their opinions is diminished to any degree. Assuming that the injuries in 1970 and 1980 contributed to claimant's current back condition, there is no evidence that they are the sole cause of his present back problems. As a result, knowledge of these injuries is not necessary in determining whether claimant's compensable injuries in 1975, 1976 and 1978 also materially contributed to his current condition. Under these circumstances, we are not persuaded that Drs. Kiest and Ulbrich would have rendered a different opinion if they had been apprised of the 1970 and 1980 injuries.

We, therefore, affirm the Referee's ultimate determination that claimant's right knee and low back conditions

are compensable. Accordingly, the insurer is responsible for reasonable and necessary medical treatment for those conditions.

Temporary Disability Issues

Claimant's entitlement to temporary disability compensation for his compensable conditions is addressed in our own motion order in WCB Case No. 86-0226M, issued this date. Here, we limit our review to Referee Shebley's ruling that the insurer is not obligated to pay temporary disability compensation under Referee Mulder's March 16, 1987 order, reissued April 10, 1987. Referee Shebley found that the compensation awarded by Referee Mulder was limited to medical services. As a result, Referee Shebley concluded that the insurer was under no obligation to pay temporary disability compensation under Referee Mulder's order. Claimant challenges that ruling.

We affirm and adopt Referee Shebley's conclusions and opinion on this issue. As a result, it is not necessary for us to further address claimant's contention that the insurer was obligated to pay temporary disability compensation pending Board review of Referee Mulder's order, or the related penalty and attorney fee issue raised by claimant. Nor is it necessary to address the insurer's contention that an award of temporary disability was beyond Referee Mulder's jurisdiction.

ORDER

Referee Mulder's order, dated March 16, 1987, and reissued April 10, 1987, is affirmed. Claimant's attorney is awarded an assessed fee of $500 for services on Board review in regard to Referee Mulder's order. Referee Shebley's orders dated February 23 and March 13, 1989 are also affirmed. The Board approves a client-paid fee, not to exceed $500, for legal services rendered in regard to Referee Shebley's orders.

PATRICK DUFFY, Claimant
Thomas O. Carter, Claimant's Attorney
Liberty Northwest, Insurance Carrier

Own Motion 86-08009
September 21, 1989
Own Motion Order

Claimant initially submitted to the Board his claim for an alleged worsening of his 1975 industrial injury. Claimant's aggravation rights have expired. By Own Motion Order, issued May 16, 1986, we reopened claimant's 1975 injury claim for additional temporary disability benefits. At that time, claimant's treating surgeon had recommended arthroscopic surgery for both knees. The insurer took the position that our May 16, 1986 Own Motion Order reopened claimant's claim for the left knee condition, only. Claimant now requests that the Board clarify that our May 16, 1986 order reopened his 1975 injury claim for both the right and left knee conditions.

We consolidate claimant's request with our review in WCB Case No. 86-08009. That case concerns the insurer's June 2, 1986 partial denial of claimant's right knee condition. By Opinion and Order, issued March 16, 1987 and reissued April 10, 1987, Referee Mulder reversed the insurer's denial, and the insurer requested Board review.

This date, we have issued our Order on Review in WCB Case No. 86-08009. In that order, we concluded that the Board's May 16,

1986 Own Motion Order reopened claimant's 1975 injury claim for his left knee condition, only. See Patrick Duffy, 41 Van Natta 1478(Issued this date). Accordingly, our May 1986 order created no obligation to pay temporary disability compensation for claimant's right knee condition.

However, our order in WCB Case No. 86-08009 does affirm Referee Mulder's determination that claimant's right knee condition is materially related to a compensable bilateral knee injury in July 1976. Accordingly, it is now appropriate for us to determine whether claimant's 1976 injury claim should be reopened for temporary disability compensation for his right knee condition.

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

Following our review of this record, we are persuaded that claimant's compensable right knee condition has worsened requiring surgery. Accordingly, his 1976 injury claim is reopened for temporary disability compensation to commence the date he is hospitalized for surgery for the right knee, and to continue until his right knee condition becomes medically stationary or he returns to regular work at his regular wage, whichever is earlier.

As a reasonable attorney fee, claimant's attorney is awarded 25 percent of the increased compensation awarded under this order, not to exceed $500. Reimbursement from the Reopened Claims Reserve is authorized to the extent allowed under ORS 656.625 and OAR 436, Division 45. When appropriate, the 1976 injury claim should be closed by the insurer pursuant to OAR 438-12-055.

IT IS SO ORDERED

TONY FAZZOLARI, Claimant
Robert L. Burns, Claimant's Attorney
Beers, Zimmerman & Rice, Defense Attorneys

WCB 85-16090
September 21, 1989
Order on Remand

This matter is before the Board on remand from the Court of Appeals. Fazzolari v. United Beer Distributors, 91 Or App 592, recon 93 Or App 103, rev den Or 236 (1988). We have been instructed to determine whether claimant was able to work after the time when he was released to work by his attending physician and before he was medically stationary. If he was able to work, the court has held that the employer is entitled to an offset for the temporary disability benefits paid between the date he was released to work and prior to the date he became medically stationary. We proceed with our determination.

FINDINGS OF FACT

In November 1984, claimant, driver/salesman for a beer distributorship, filed a claim for a bruised right hand. He asserted that this problem was attributable to striking the sides of beer cases to open perforated handles. Dr. Button, claimant's treating surgeon, diagnosed acute extensor tendinitis of the right forearm/wrist.

The insurer accepted the claim and commenced paying temporary total disability effective December 3, 1984. Shortly thereafter, claimant developed an abscess of the dorsum of his right hand, which resulted in a December 17, 1984 drainage surgery.

On March 22, 1985, Dr. Button released claimant to return to regular work without restriction. Noting that claimant was not medically stationary, Button recommended that the claim remain open for several more months. Thereafter, claimant returned to his employer, but was advised not to return until he was capable of fully performing his regular work activities.

For the next four months, claimant received physical therapy. He did not return to work until after August 12, 1985, which was as soon as the employer would permit him to return to his regular work activities. Claimant's condition did not become medically stationary until August 23, 1985. The insurer continued to pay temporary disability benefits until September 2, 1985.

An October 30, 1985 Determination Order awarded temporary total disability from December 2, 1984 through March 22, 1985, but no permanent disability. The Determination Order did not allow an offset for the temporary total disability paid after March 22, 1985 through September 2, 1985.

ULTIMATE FINDINGS

Claimant was not able to perform his regular work until after August 12, 1985.

CONCLUSIONS OF LAW

An employer is entitled to an offset of benefits that have been paid only if the evidence shows that claimant was not entitled to the benefits. Metro Machinery Rigging v. Tallent, 94 Or App 245, 248 (1988); Fazzolari v. United Beer Disributors, 91 Or App 592, on recon 93 Or 103, rev den 307 Or 236 (1988). Temporary total disability benefits are awarded to replace wages lost by reason of a temporary disability. ORS 656.210; Cutright v. Weyerhaeuser Co., 299 Or 290, 295 (1985).

We are pesuaded that claimant was not able to work from March 22, 1985, the date he was released to regular work without restrictions, until he returned to work after August 12, 1985. Inasmuch as claimant was entitled to temporary disability benefits during this period, we conclude that the insurer is not entitled to offset this compensation against claimant's future permanent disability benefits. However, we hold that the insurer is entitled to recover temporary disability benefits made subsequent to claimant's return to work and September 2, 1985, when the insurer stopped paying such benefits.

In reaching our conclusion, we find claimant's credible testimony to be persuasive. Moreover, the employer did not permit claimant to return to work until he could physically accomodate his regular work activites. Finally, claimant's referral to, and participation in, physical therapy lends further support for the conclusion that the release to work was contingent upon his ability to perform his prior work activities.

The insurer contends that claimant's compensable

condition became medically stationary on March 22, 1985, which was also the date Dr. Button released him to return to work without restictions. On that basis, the insurer contends it is entitiled to an offset. The insurer bases its contention that claimant was stationary in March on Dr. Button's subsequent "concurrence" with the insurer's counsel's "interpretation" that a noncompensable chronic musculotendonitis condition, as opposed to claimant's compensable condition, remained unstationary until August 23, 1985.

Such an argument, if followed, would lead to a conclusion which is contrary to findings rendered in the Referee's order, as well as our Order on Review, i.e., claimant's condition was medically stationary on August 23, 1985. Moreover, the court has essentially determined that claimant was medically stationary on August 23, 1985. 91 Or App at page 595. Finally, our express instructions are to determine "whether claimant was able to work after the time when he was released to work by the attending physician and before he was medically stationary." 91 Or App at page 596.

Inasmuch as the insurer's contention raises an issue which exceeds our authority on remand, we are not authorized to consider it. In any event, had we addressed the issue, we would consider Dr. Button's subsequent "concurrence" with the insurer's "interpretation" unpersuasive when compared with his earlier opinions. Specifically, we would refer to Button's March 22, 1985 release to regular work, at which time he recommended that claimant's claim remain open for several more months, and Button's August 23, 1985 closing report, when he found claimant's condition medically stationary without differentiating between compensable and so-called noncompensable conditions.

Accordingly, the insurer is permitted to offset the temporary disability benefits paid after claimant's return to work after August 12, 1985 through September 2, 1985, against any future awards of permanent disability.

IT IS SO ORDERED.

JEFFERY P. KEIMIG, Claimant
Karen M. Werner, Claimant's Attorney
Luvaas, Cobb, et al., Defense Attorneys

WCB 86-14810
September 21, 1989
Second Order of Dismissal

The insurer seeks Board authorization of a client-paid fee for services rendered by its counsel in this matter which culminated in our August 25, 1989 Order of Dismissal. We declined to authorize such a fee because the record lacked an executed retainer agreement or referral letter in this particular case. In response, the insurer has submitted a letter confirming counsel's representation in this case.

After review of the statement of services and considering the factors set forth in OAR 438-15-010(6), we approve a client-paid fee, payable from the insurer to its counsel, not to exceed $2,290.50. In so doing, we note that we have not approved the insurer's counsel's request for authorization insofar as it pertained to a charge for "word processor" time. Inasmuch as costs incurred by an attorney in pursuing a matter on behalf of a party are not included in fees paid to an attorney, Board authorization is not required. See OAR 438-15-005(4), (5) & (7); Janelle I. Neal, 40 Van Natta 359 (1988).

Accordingly, as supplemented herein, we adhere to and

republish our August 25, 1989 order. The parties' rights of appeal shall continue to run from the date of our prior order.

IT IS SO ORDERED.

JESUSA ORTIZ, Claimant
Steven C. Yates, Claimant's Attorney
Schwabe, et al., Defense Attorneys
Stoel, Rives, et al., Defense Attorneys

WCB 87-11503 & 86-15254
September 21, 1989
Order on Reconsideration

Claimant requests reconsideration of our August 24, 1989 Order on Review that modified a Referee's attorney fee award for services rendered in a responsibility case where no order designating a paying agent pursuant to ORS 656.307 had issued. Specifically, we held that the $1,350 attorney fee was payable by Liberty Northwest in addition to, rather than out of, claimant's compensation.

Claimant seeks an "insurer-paid" attorney fee for prevailing in her appeal of the Referee's attorney fee award. We deny the request.

Where a claimant finally prevails on Board review from an order or decision denying a claim for compensation, claimant is entitled to a reasonable attorney fee payable by the carrier. ORS 656.386(1). Furthermore, if a request for Board review is initiated by a carrier and the Board finds that the compensation awarded to claimant should not be disallowed or reduced, the carrier is required to pay a reasonable attorney fee. ORS 656.382(2).

Here, claimant did not finally prevail from an order denying her claim for compensation. Rather, she prevailed in her contention that the Referee's attorney fee award should be modified. Therefore, claimant is not entitled to an insurer-paid attorney fee pursuant to ORS 656.386(1).

Moreover, a carrier did not request review of the Referee's order, claimant did. Liberty Northwest did cross-request review, contending that claimant was not entitled to any attorney fee. However, attorney fees are not "compensation" within the meaning of ORS 656.382(2). See Saxton v. SAIF, 80 Or App 631 (1986); Dotson v. Bohemia, Inc., 80 Or App 233 (1986). Consequently, claimant is also not entitled to an insurer-paid attorney fee under 656.382(2).

Accordingly, our August 24, 1989 order is withdrawn. On reconsideration, as supplemented herein, we adhere to and republish our August 24, 1989 order, effective this date. The parties' rights of appeal shall run from the date of this order.

IT IS SO ORDERED.

JOY J. BROOKSHIRE, Claimant
Peter O. Hansen, Claimant's Attorney
SAIF Corp Legal, Defense Attorney

Own Motion 86-0689M
September 22, 1989
Own Motion Order on Reconsideration

Claimant requests reconsideration of the Board's August 23, 1989, Own Motion Order, which upheld the SAIF Corporation's termination of temporary disability benefits as of the date that claimant returned to regular work, but set aside SAIF's Notice of Closure as premature. Claimant contends that temporary disability benefits should continue until she is medically stationary and seeks a penalty and attorney fee for SAIF's improper closure of her claim.

We upheld SAIF's termination of temporary disability benefits based on a questionnaire to which claimant responded that she had returned to "regular or full work" on January 23, 1989. Claimant now asserts that benefits should have been continued because she was not released to her original job-at-injury. We find no evidence to support claimant's contention that she did not return to her regular work. In fact, claimant herself indicated that she returned to "regular" or full work. Therefore, we continue to conclude that SAIF's termination of temporary disability benefits was proper.

We turn to the penalty and attorney fee issue. SAIF closed claimant's claim based on a medical report which projected that claimant would be medically stationary on a future date. However, we were not persuaded by that report, particularly in the absence of a subsequent report confirming the projection. Consequently, we did not find that claimant was medically stationary and, hence, concluded that claim closure was premature. Nevertheless, considering the above-mentioned report, we are not persuaded that SAIF's closure of the claim was unreasonable. Therefore, we decline to assess a penalty or related attorney fee for its conduct.

Accordingly, our August 23, 1989 order is withdrawn. On reconsideration, as supplemented herein, we adhere to and republish our August 23, 1989 order, effective this date.

IT IS SO ORDERED.

FRANK T. SCHUFA, Claimant
Liberty Northwest, Insurance Carrier

Own Motion 89-0106M
September 22, 1989
Own Motion Order

The insurer has submitted to the Board claimant's claim for an alleged worsening of his October 30, 1980, industrial injury. Claimant's aggravation rights have expired. The insurer has accepted responsibility for claimant's surgery but opposes claim reopening for temporary disability benefits on the ground that claimant has withdrawn from the work force. The insurer also requests that, if we reopen the claim for temporary total disability, benefits be based on claimant's earnings for the 12 months preceding the date of worsening of his condition.

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

Following our review of this record, we are persuaded that claimant's compensable ulcerative colitis condition has worsened requiring surgery for gastrointestinal bleeding. In addition, claimant has submitted persuasive evidence of his continued involvement in the work force. Accordingly, claimant's claim is reopened with temporary disability benefits to commence November 26, 1988, the date of hospitalization, 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.

Finally, we decline the insurer's request to base temporary disability benefits on claimant's earnings for the 12 months preceding the worsening of his condition. Claimant is entitled to benefits calculated in accordance with the law at the time of injury. ORS 656.202(2). Claimant was injured in 1980. At that time, ORS 656.210 provided that temporary total disability benefits shall be based on the worker's wage at the time of injury. See Or Laws 1975, ch 663, § 1. Claimant's benefits shall be calculated accordingly.

IT IS SO ORDERED.

MICHAEL EDWARDS, Claimant
Pozzi, et al., Claimant's Attorneys
SAIF Corp Legal, Defense Attorney

Own Motion 88-0033M
September 26, 1989
Own Motion Order Denying Reconsideration

The SAIF Corporation requests reconsideration of the Board's August 9, 1989, Own Motion Order that set aside its October 25, 1988, Notice of Closure as premature. Alternatively, SAIF requests abatement of the aforementioned order in order to allow additional time for reconsideration. SAIF's reconsideration request is accompanied by additional medical evidence concerning claimant's medically stationary status.

If a motion for reconsideration is accompanied by additional evidence not otherwise in the record, the additional evidence will only be considered if we find that: (1) the record, without the additional evidence, has been improperly, incompletely or otherwise insufficiently developed; and (2) the additional evidence was unobtainable with due diligence by the moving party prior to its submission to the Board. OAR 438-12-065(3). Here, the additional evidence is a letter dated September 1, 1989, from claimant's treating physician, declaring claimant's knee condition medically stationary as of October 17, 1988. Because the letter concerns claimant's condition as it existed during the ten months preceding our original order, we do not find that the additional evidence was unobtainable with due diligence prior to its submission to the Board. Accordingly, SAIF's request for reconsideration and, alternatively, abatement is denied.

Appeal rights shall continue to run from August 9, 1989, the date of our Own Motion Order.

IT IS SO ORDERED.

NORMAN L. MARKS, Claimant
Hampson, et al., Claimant's Attorneys
SAIF Corp, Insurance Carrier

Own Motion 89-0254M
September 26, 1989
Own Motion Order Denying Reconsideration

Claimant has requested that the Board reconsider its May 30, 1989 Own Motion Order in the aforementioned case. Pursuant to Board rules, a motion for reconsideration shall be denied if not submitted to the Board in a timely manner. See OAR 438-12-065(2). In order to be timely, the Board must receive the motion for reconsideration within 30 days of the date of mailing of the Board's order. Id. Here, claimant's request for reconsideration was untimely, as it was not received by the Board until July 3, 1989.

Accordingly, the request for reconsideration is denied.

IT IS SO ORDERED.

ROBIN MITCHELL, Claimant
Bischoff & Strooband, Claimant's Attorneys
EBI Companies, Insurance Carrier

Own Motion 84-0243M
September 26, 1989
Own Motion Determination

The Board issued its Own Motion Order in the above-entitled matter on December 4, 1984, reopening claimant's claim for a worsened condition related to his 1976 back injury. The insurer terminated claimant's temporary disability compensation on May 18, 1988 and issued a "self-closure" of the claim on May 25, 1988. Claimant now seeks Board review of the insurer's closure, contending that he is entitled to a greater award of permanent partial disability.

The date of reopening of claimant's injury claim preceded the effective date of the current own motion law. Hence, this case is governed by former ORS 656.278 and the rules promulgated thereunder. Under the former law, only the Board had authority to close a claim reopened under its own motion authority. Accordingly, the insurer's purported self-closure is null and void.

We evaluate the claim for closure at this time. Claimant's treating physician found him medically stationary as of January 18, 1988. We defer to the treating physician's opinion and conclude that claimant became stationary on that date. Accordingly, his claim is closed with an award of temporary total disability for the period August 10, 1984 through April 22, 1988.

Claimant is also awarded 5 percent (7.5 degrees) scheduled permanent disability for each leg, and an additional 50 percent (160 degrees) unscheduled permanent disability for his back condition, for a total unscheduled award of 75 percent (240 degrees). Deduction of overpaid temporary disability, if any, from unpaid permanent disability is approved.

Finally, claimant's attorney is awarded a fee equal to 25 percent of the additional permanent disability compensation awarded under this order, not to exceed $500.

IT IS SO ORDERED.

JERRY A. MURPHY, Claimant
Allan Coons, Claimant's Attorney
Kimberly Wallan, Defense Attorney

WCB 87-15314
September 26, 1989
Order on Review

Reviewed by board members Gerner and Myers.

Claimant requests review of Referee Brown's order that upheld the insurer's denial of his aggravation claim for a low back condition.

The Board reverses the order of the Referee.

ISSUE

Whether claimant has proven an aggravation of his September, 1985, compensable low back injury.

FINDINGS OF FACT

Claimant compensably injured her low back in September, 1985, while working as a cook in a retirement center. She sought treatment from Dr. Womack, M.D., for complaints of low back pain accompanied by a burning sensation. Womack treated with physical therapy and prescription medication. In December, 1986, claimant's condition became medically stationary. Womack restricted her to occasional lifting beyond 10 pounds, and no bending, squatting, crawling, or climbing.

A Determination Order closed claimant's claim in January, 1987, awarding a period of temporary disability and 20 percent unscheduled permanent disability.

Thereafter, claimant continued to treat with Dr. Womack. In May, 1987, she began working in a nursing home. Her duties resulted in occasional exacerbations of low back pain radiating into her left lower extremity.

On July 20, 1987, a stipulation awarded claimant an additional 10 percent unscheduled permanent disability.

Dr. Womack examined claimant on August 2, 1987, and found that she was "essentially stable without deterioration." Near the end of August, 1987, however, claimant left her nursing home job due to back and left leg pain. Her back and left leg were swollen. This swelling and associated pain made it difficult for her to stand up. Her left leg also developed numbness in late August, 1987.

Claimant returned to Womack on September 2, 1987. Womack released her from work for two weeks and ordered a CT scan, which was negative. On September 7, 1987, Womack reexamined claimant and found that she had an antalgic gait with associated low back spasm and tenderness. Consequently, he extended her work release for an additional four weeks. Upon reexamination on September 16, 1987, Womack continued claimant's work release until he could evaluate her MRI results. In so doing, Womack stated that if the MRI failed to show signs of lumbar stenosis, then it was his opinion that claimant had experienced a reexacerbation of her September, 1985, compensable injury.

After obtaining the MRI results, Dr. Womack reported on

October 5, 1987, that claimant had experienced an aggravation of her low back condition.

The insurer issued an aggravation denial on September 29, 1987, asserting that claimant's low back condition had not worsened since the "last arrangement of compensation by Determination Order dated January 7, 1987[,] . . . ."

ULTIMATE FINDINGS OF FACT

Claimant's compensable low back condition has worsened to the point that she is less able to work. This worsening is greater than waxings and wanings anticipated in the last arrangement of compensation.

CONCLUSIONS OF LAW

In order to establish a compensable aggravation claim, claimant must show "worsened conditions resulting from the original injury." ORS 656.273; see, Perry v. SAIF, 307 Or 654 (1989). In addition, claimant must establish that as a result of such worsening he is more disabled, i.e., less able to work, either temporarily or permanently, the he was at the time of the last arrangement of compensation. Smith v. SAIF, 302 Or 396, 399 (1986). "Worsened conditions" may be either a worsening of the underlying condition or a symptomatic worsening. Id. If the worsening is symptomatic, claimant must prove that the symptomatic flare-up is greater than was contemplated at the time of the last arrangement of compensation. Gwynn v. SAIF, 304 Or 345, on remand 91 Or App 84 (1988).

The last arrangement of compensation in this case was the stipulation of July, 1987, which provided, inter alia:

> "[T]his settlement contemplates the claimant's present loss of earning capacity resulting from the physical restrictions of 10 pounds lifting not more than 5 times per day and no bending, as recommended by her attendig physician."

In our view, the above quoted language indicates that the parties contemplated future symptomatic flare-ups in claimant's condition. We, therefore, turn to whether claimant's flare-up in late August, 1987, was greater than that contemplated.

As a result of claimant's flare-up, she discontinued her nursing home job and sought treatment from Dr. Womack on September 2, 1987. Womack took her off her work. On September 7, 1987, Womack's examination revealed an antalgic gait with associated low back spasm and tenderness. Consequently, he extended claimant's work release for four additional weeks. Upon reexamination on September 16, 1987, Womack continued claimant's work release until he could evaluate the results of her MRI. Although the MRI revealed no signs of significant neuromusculoskeletal deterioration, Womack opined that claimant had suffered a "re-aggravation of her low back condition."

Given Dr. Womack's work release in excess of four weeks, his

findings on examination, and his unrebutted opinion that claimant had suffered an "exacerbation" or "re-aggravation," we conclude that the symptomatic worsening was greater than was anticipated at the time of the last arrangement of compensation. Dr. Womack also causally linked claimant's worsening to her compensable injury, stating, inter alia:

> "Should this [MRI] study be negative, [claimant] may be assumed to have a reexacerbation of her previous injury without indication for surgical intervention." (Emphasis added).

Womack's opinion is uncontradicted. Moreover, as claimant's treating physician, we find no persuasive reasons to not accord his opinion great weight. See Weiland v. SAIF, 64 Or App 810 (1983).

Accordingly, we conclude that claimant has proven a compensable aggravation.

ORDER

The Referee's order, dated March 1, 1988, is reversed. The insurer's aggravation denial is set aside and it is instructed to proccess claimant's aggravation claim according to law. Claimant's attorney is awarded a reasonable assessed fee of $2,275 for services at hearing and on Board review, to be paid by the insurer.

PATRICK L. PADFIELD, Claimant
Vick & Gutzler, Claimant's Attorneys
Davis & Bostwick, Defense Attorneys

WCB 87-14763
September 26, 1989
Order on Review

Reviewed by Board Members Gerner and Myers.

The insurer requests review of that portion of Referee Leahy's order that set aside its denial of medical services for claimant's current complaints of neck, back, right shoulder/arm, and bilateral leg pain.

The Board reverses in part and affirms in part.

ISSUE

The compensability of claimant's medical services for his current complaints of neck, back, right shoulder/arm, and bilateral leg pain.

FINDINGS OF FACT

Claimant, 36 at the hearing, sustained a compensable nondisabling injury to his neck, back, and right arm in March, 1984. Later that day, he was examined by Dr. Berry, his treating chiropractor. Berry released him to regular work and treated conservatively for a few months.

In March, 1985, claimant was examined by Dr. Gatterman, a chiropractor. Gatterman found that claimant was medically stationary without permanent residuals.

Claimant returned to Dr. Berry in July, 1987, with complaints

of neck, back, right arm, and bilateral knee pain. Berry declared that claimant was not medically stationary and recommended further chiropractic treatments.

In October, 1987, while claimant's claim remained open, the insurer issued a denial of claimant's current need for medical services.

In November, 1987, claimant was examined by Dr. Duncan, a chiropractor. Duncan found no causal relationship between claimant's current condition and his compensable injury of March, 1984. Later that month, claimant was seen by Dr. Harrington, a chiropractor. Harrington found that claimant remained symptomatic and in need of further chiropractic treatments.

At the time of the hearing, no Determination Order had issued and claimant's claim remained open.

ULTIMATE FINDINGS OF FACT

Claimant's current neck, back and right arm conditions are inseparable from his compensable neck, back and right arm conditions. Claimant's bilateral knee condition is separable from his compensable conditions. Claimant's compensable injury is a material cause of his current neck, back and right arm conditions.

CONCLUSIONS OF LAW

PREMATURE DENIAL

Despite finding that claimant's current need for medical services was not compensable on the merits, the Referee set aside the insurer's denial on procedural grounds. In so doing, he relied in part on the case of John L. Katzenbach, 39 Van Natta 798 (1987), to find that the insurer had issued an impermissible pre-closure denial. Since the time of the Referee's order, our decision in Katzenbach has been reversed. See Boise Cascade Corporation v. Katzenbach, 307 Or 391 (1989).

In Katzenbach, the employer accepted the worker's industrial injury claim for a right wrist condition as a nondisabling injury. The worker's condition was initially diagnosed as tendonitis, but, after swelling appeared, avascular necrosis was diagnosed. Thereafter, the employer denied current medical services, contending that the worker's symptoms were not related to his compensable injury. The Board set aside the employer's denial, reasoning that a partial denial of a previously accepted inseparable condition, issued while the claim was still open, was not permissible. Noting, however, that no one authorized to do so had found the worker's two conditions "inseparable," the court held that the Board and the Court of Appeals had erred in setting aside the denial on procedural grounds.

Here, unlike Katzenbach, there are not divergent diagnoses of the worker's compensable conditions. In fact, save for claimant's bilateral knee condition, which we do find separable from his compensable neck, back, and right arm conditions, this case does not involve separate medical conditions. There has never been any contention among the medical experts or the parties, that claimant's current neck, back, and right arm conditions are separable from his compensable neck, back, and right arm conditions. Although the medical experts may disagree as to the etiology of claimant's current

complaints, e.g., Dr. Duncan ascribing claimant's current cervical complaints to preexisting degenerative joint disease, we do not view their opinions as offering new diagnoses or conditions.

We conclude that the denial was a premature pre-closure denial insofar as it concerned claimant's current neck, back, and right arm conditions. Regarding claimant's bilateral knee condition, however, we find that it is a separate condition from his neck, back, and right arm conditions. Accordingly, we further conclude that the Referee erred in setting aside the denial as to claimant's bilateral knee condition.

In summary, we conclude that the denial was a premature "pre-closure" denial solely with respect to claimant's neck, back, and right arm conditions, but, we uphold that portion of the denial pertaining to claimant's bilateral knee condition.

THE MERITS

In view of the fact that although the denial was premature, it may become valid with the first closure, see, Guerrero v. Stayton Canning Co., 92 Or App 209 (1988), we address the merits. We reverse in part the Referee's finding that claimant has not proven the compensability of his current need for medical services. A worker is entitled to reasonable and necessary medical services for the disabling results of a compensable injury, even if pre-existing problems contribute to his disability. Van Blokland v. Oregon Health Sciences University, 87 Or App 694 (1988); see ORS 656.245(1).

Here, the medical evidence is divided. After reviewing the medical evidence, in the light of claimant's testimony, we are largely persuaded by the opinion of Dr. Berry, as corroborated by Dr. Harrington, that claimant's neck, back and right arm conditions are caused by the compensable injury. Unlike Drs. Gatterman and Duncan, Berry has treated claimant since the outset of his March, 1984, compensable injury, and periodically since that time. Exs. 5, 8, & 11. He, therefore, was in a superior position to assess claimant's continued need for medical treatment. See Weiland v. SAIF, 63 Or App 810 (1984). Moreover, we find no persuasive reasons not to assign great weight to the majority of his opinion.

We are not persuaded, however, by that portion of Dr. Berry's opinion that indicates claimant has a compensable bilateral knee condition. There is no evidence that claimant was injured or treated for a bilateral knee condition following his compensable injury of March, 1984. The first medical document to indicate that such a condition existed, is Berry's First Medical Report of July, 1987. Yet, Berry provided no medical explanation linking the effects of claimant's compensable injury to the onset of a bilateral knee conditon.

In sum, we find that claimant has proven that his current need for medical services includes treatment to his neck, back, and right arm and that his compensable injury is a material cause of his current neck, back and right arm conditions. He has failed to prove that his knee condition is a material consequence of his compensable injury.

ORDER

The Referee's order, dated February 16, 1988, is reversed in

part and affirmed in part. The insurer's denial is upheld insofar as it pertains to a denial of claimant's bilateral knee condition. All remaining portions of the Referee's order are affirmed. Claimant's attorney is awarded an assessed fee of $600, to be paid by the insurer. The Board approves a client-paid fee, payable from the insurer to its attorney, not to exceed $800.50.

JACKIE L. PIERCE, Claimant
Haugh & Foote, Claimant's Attorneys
Moscato & Byerly, Defense Attorneys

WCB 87-15864
September 26, 1989
Order on Review

Reviewed by board members Gerner and Myers.

Claimant requests review of Referee Hoguet's order that upheld the self-insured employer's denial of his left knee condition. We reverse the Referee's order insofar as it upheld a denial of a left knee strain.

The Board modifies the order of the Referee.

ISSUE

The sole issue is the compensability of claimant's left knee condition.

FINDINGS OF FACT

Claimant's left knee difficulties preexisted the incident at issue of September 9, 1987. As a result of an injury to his left knee in 1955, he underwent a lateral meniscectomy. In 1975, he reinjured his left knee in an industrial injury. As a result, he received an award of 15 percent scheduled permanent disability. Thereafter, he sought occasional treatment for left knee effusion, pain, weakness, and occasional give way. In addition, claimant's excessive weight (i.e., at the time of the hearing claimant was 5'-8" and 265 pounds) was a concern of Dr. Gambee, an orthopedic surgeon, as far back as 1977.

On September 9, 1987, claimant's left knee gave way while he was performing his job duties. He had been standing and assembling parts at his work station for approximately 1-1/2 to 2 hours, when he leaned over to his left to pick up a part out of a bin. As he did so, his left knee gave way resulting in sharp pain. He caught himself before he fell to the floor. Throughout the balance of the work day, he experienced 12 similar incidents.

On September 10, 1987, claimant began treating with Dr. Goldberg, M.D. Goldberg diagnosed a lateral collateral ligamentous injury and took him off work for 10 days.

After returning to work on September 22, 1987, claimant filed an industrial injury claim. He specifically identified the "[n]ature of injury or disease[,]" as a "STRAIN."

On October 8, 1987, the insurer denied the compensability of claimant's "left knee condition[,]" contending that there was no specific on-the-job accident and no medical evidence to substantiate a work related injury.

Claimant was examined by Dr. Thomas, an orthopedist, on December 22, 1987. Thomas diagnosed "chondromalacia of the left patella and osteoarthritis lateral compartment of the left knee."

ULTIMATE FINDINGS OF FACT

Claimant sustained a left knee strain as a material result of leaning on his left leg, while performing his job duties on September 9, 1987.

CONCLUSIONS OF LAW

The Referee cited to several "unexplained fall" cases and concluded that claimant had not proven compensability. We disagree.

In our view, this case should not be analyzed as an "unexplained fall" case. The court in Falkenberg v. SAIF, 69 Or App 159 (1984), provided, inter alia:

> "We conclude that the Board erred in applying an 'unexplained fall' analysis to this case. That analysis is applicable only when the claimant falls for unknown reasons and injury results from the fall." (Emphasis added).

Here, as in Falkenberg, we find that the record before us provides an explanation for claimant's September, 1987, fall. First, prior to his fall, claimant had a history of left knee difficulties. After his industrial injury of 1975, he experienced occasional left knee effusion, pain, weakness, and give way. Second, claimant's excessive weight was noted as a contributing factor to his left knee difficulties as early as 1977. Last, claimant's on-the-job activities of September 9, 1987, caused him to lean on his left leg with most or all of his weight.

As a further preliminary matter, we must determine whether claimant's left knee condition should be analyzed as an injury or occupational disease. What sets injury cases apart from occupational diseases is that they cannot said to be unexpected, given the nature of the claimant's work activities, and they are sudden rather than gradual in onset. Valtinson v. SAIF, 56 Or App 184 (1982).

Here, we are not persuaded that claimant was continually exposed to the particular kind of work activity that he was engaged in at the time of his September, 1987, fall. Accordingly, he testified, inter alia:

> "Q. All right, and you [claimant] do this. I mean, that's what you do all the time, right?
>
> "A. That's what I do. Not all the time. I do different jobs, whatever they need done.
>
> "Q. That's what you were doing on this particular day, though?

"A. But at that particular time, yeah, that's what I was doing.

"Q. That's what you'd been doing for an hour-and-a-half to two hours?

"A. Yeah. I've done the job before." (Emphasis added).

Moreover, claimant's fall was sudden in onset. His work activity at that moment required him to lean on his left leg with most, if not all, his approximate 265 pounds. Although he had a prior history of left knee difficulties, his fall was a sudden event that resulted in immediate pain. Accordingly, we conclude that his September, 1987, fall, should be analyzed as an injury.

In injury cases, a worker must prove by a preponderance of the evidence that the industrial injury was a material contributing cause of his existing disability or need for medical treatment. Harris v. Albertson's Inc., 65 Or 254 (1983); former ORS 656.005(7)(a). A worker need not, however, prove an aggravation or worsening of her underlying condition. Jameson v. SAIF, 63 Or App 553 (1983).

There are two medical opinions in this case. On November 16, 1987, Dr. Goldberg reported, inter alia:

"It appears that the left knee injury occurred sometime after work standing at a work bench. [Claimant] recalled no particular injury but his description of the way he stands and works at the bench can certainly be the source of that injury."

"* * * * *.

"This is the type of injury that could occur with a work injury but is not limited specifically to it."

The following month, Dr. Thompson stated, inter alia:

"In regards to the specific injury of 9/9/87,...[b]ased on the history that he gives me, the squatting and reaching into the bins was the etiology of his pain.

Taken together, the opinions of Drs. Goldberg and Thompson indicate that claimant's work activities on September 9, 1987, contributed to cause his left knee give way. The other causative factors were claimant's preexisting left knee difficulties and his excessive weight. It is axiomatic, however, that an employer takes the worker as he finds him. Aquillon v. CNA Insurance, 60 Or App 231 (1982). We, therefore, conclude that the particular job duty that claimant was engaged in at the time of his September, 1987, fall, materially contributed to cause his resulting left knee condition and need for medical treatment.

As a final matter, we find that claimant's compensable "condition" is limited to a left knee strain and does not include his preexisting arthritis condition. See Tucker v. Liberty

Northwest Insurance Co., 87 Or App 607 (1987). As we found above, on his industrial injury claim form, claimant listed his injury as a "strain." Moreover, the unrebutted medical evidence is that claimant's symptoms completely resolved within 10 days of his injury without additional permanent impairment. Accordingly, Dr. Thompson reported, inter alia:

> "I feel that [claimant] had a temporary exacerbation of his previous osteoarthritis. He was symptomatic for ten days but since that time, has essentially been the same as he was prior to the incident. Based on the history that he gives me, the squatting and reaching into the bins was the etiology of his pain. He is back to his pre-exacerbation level. I do not feel that there has been an increase of his impairment of the left knee but he does have an impairment based on previous lateral menisctomy and his 1980 [sic] injury. He is able to perform his regular work."

We, therefore, conclude that claimant's left knee strain, not his underlying arthritis condition, was materially caused by his work activity at the time of his September, 1987, fall.

ORDER

The Referee's order, dated February 18, 1988, is reversed in part. In lieu of the Referee's order, the employer's denial is set aside insofar as it pertains to claimant's left knee strain. As it pertains to claimant's underlying left knee osteoarthritis condition, the denial is upheld. The employer is instructed to process claimant's claim for a left knee strain according to law. Claimant's attorney is awarded an assessed fee of $1,400 for services at the hearing and on Board review, to be paid by the employer. The Board approves a client-paid fee, payable from the employer to its attorney, not to exceed $959.50.

BRYAN D. WARRILOW, Claimant
Doblie & Associates, Claimant's Attorneys
Schwabe, et al., Defense Attorneys

WCB 86-09029
September 26, 1989
Order on Remand

This matter is before the Board on remand from the Court of Appeals. Weyerhaeuser Company v. Warrilow, 96 Or App 34 (1989). The court has reversed our order, Bryan D. Warrilow, 40 Van Natta 521 (1988), which concluded that the employer's partial denial was procedurally improper. The court has remanded, stating that the question of whether the denial should be sustained on the merits "may be resolved at the appropriate time." We conclude that this is the appropriate time to resolve the compensability question and proceed with our review.

FINDINGS

On March 3, 1986, claimant, 38 years of age at hearing, suffered a compensable injury when a roller he was standing on gave way, causing his left foot to fall into a hole. The next day, he

sought chiropractic treatment, complaining of pain in the neck, left shoulder, midback, and left ankle. The following day, he filed his claim, listing the nature of injury as "ankle, neck, shoulder (left)".

X-rays revealed mild degenerative changes at C4-5 and C5-6 with mild osteophytic spurring. A myelogram reflected mild osteoarthritis in the cervical area, but did not suggest that claimant was experiencing a symptomatic cervical radiculopathy or herniated disc.

The claim was initially deferred. Following an investigation, the employer accepted responsibility for medical treatment related to the effects of the work incident. Finding no evidence relating the degenerative changes to the work incident, the employer denied responsibility for them.

The degenerative changes and osteophytic spurring in claimant's cervical spine were neither caused nor worsened by the compensable injury.

ULTIMATE FINDINGS OF FACT

The compensable injury is not a material contributing cause of degenerative changes and osteophytic spurring of claimant's cervical spine spine or its worsening.

CONCLUSIONS

Dr. Rozycki, radiologist, opined that the cervical spurring demonstrated in claimant's x-rays "most definitely would predate" the work incident. Rozycki further noted that osteophytic spurring is a result of chronic changes which occurs gradually over time. Dr. Gallo, neurosugeon, concurred with these findings, concluding that the degenerative changes and osteophytic spurring were unrelated to the work injury. These findings and opinions persuasively establish that claimant's degenerative changes and osteophytic spurring were not causally related to the work incident. Accordingly, we conclude that those conditions are not compensable.

ORDER

The Referee's order dated March 17, 1987 is reversed. The self-insured employer's denial is reinstated and upheld.

BRYAN D. WARRILOW, Claimant
Doblie & Associates, Claimant's Attorneys
Schwabe, et al., Defense Attorneys

WCB 87-09098
September 26, 1989
Order Remanding

The self-insured employer requests review of Referee Galton's order that: (1) found that claimant's injury claim had been prematurely closed by a June 5, 1987 Determination Order; (2) set aside the employer's "de facto" denial of claimant's aggravation claim; (3) awarded temporary total disability benefits; and (4) set aside the employer's partial denial of claimant's psychiatric condition. The Referee reached these conclusions on procedural grounds, reasoning that the Board's then-recent decision in Bryan D. Warrilow, 40 Van Natta 521 (1988), which had found that the employer's pre-closure partial denial had been improper, was controlling. In the event the Board's order was subsequently overturned, the Referee noted that he was prepared to "enter detailed Findings of Facts and Conclusions of Law upon any remand thereby necessitated."

The Court of Appeals has reversed the Board's 1988 order, concluding that the employer's partial denial was procedurally proper. Weyerhaeuser Company v. Warrilow, 96 Or App 34 (1989). The court has remanded for a determination of whether the denial should be sustained on the merits. Because of the court's decision, both parties seek remand in this case for the issuance of an order containing full findings of fact and conclusions of law.

Under these circumstances, which include the Referee's prior stated intentions and the parties' unanimous position, we conclude that this case has been insufficiently developed. ORS 656.295(5). Consequently, remand is an appropriate action. Accordingly, this matter is remanded to Referee Galton for reconsideration and the issuance of a final, appealable order with "detailed Findings of Fact and Conclusions of Law."

IT IS SO ORDERED.

KAROL K. WOOD, Claimant
Ackerman, et al., Claimant's Attorneys
Cummins, et al., Defense Attorneys

WCB 87-07553
September 26, 1989
Order on Review

Reviewed by Board members Gerner and Crider.

Claimant requests review of those portions of Referee Huffman's order that: (1) admitted pages 8 through 25 of Exhibit 39 into evidence; and (2) affirmed a Determination order awarding claimant 5 percent (7.5 degrees) scheduled permanent disability for each forearm, and 5 percent (16 degrees) unscheduled permanent disability for a back condition. On review, the issues are admissibility of evidence and extent of unscheduled permanent disability.

We modify on the extent issue.

FINDINGS OF FACT

We adopt the Referee's "Findings of Fact" subject to the following exceptions. The Referee found that claimant had left carpal tunnel surgery in August 1982, whereas we find that surgery was performed on the right wrist. The Referee also found that claimant's "dorsolumbar spine allowed 75 degrees of flexion" when she was examined by Dr. Zivin in August 1987. We, instead, find that claimant demonstrated 75 degrees of lumbar flexion without pain, but could bend further with pain.

We make the following additional findings.

The sleep and mood disorder claimant developed in 1984 resolved prior to hearing. That disorder was materially related to her compensable injuries and beyond her control.

At the time of hearing, claimant continued to experience disabling pain in her neck, back and writs, along with some grip loss in the right hand. Her symptoms and limitations are real to her, and she does not voluntarily exaggerate her disability.

Claimant's residual wrist and hand symptoms are attributable to compensable bilateral carpal tunnel syndrome dating back to 1982. Since that time, she has experienced

disabling pain and grip loss with strenuous and repetitive use of her arms and hands. She currently experiences frequent sharp, disabling pain in her right wrist, and similar pain in her left wrist on a less frequent basis. Her pain is associated with typing for more than one or two hours, putting weight on her hands, bending her wrists backward and lifting more than twenty pounds. She also experiences right hand grip loss which causes her to drop items at least once a day.

Claimant's residual neck and back pain is attributable to a compensable fibrositis condition. This condition has a significant psychological component. At the time of hearing, claimant continued to receive regular chiropractic treatment for her neck and back condition. She experiences constant restricted forward bending, nightly sleep interruption due to back pain, and periodic flare-ups of disabling neck and back pain. She experiences flare-ups when she stays in one position too long, performs repetitive bending, lifts more than 20 pounds, or lifts even that amount on a regular basis.

Claimant's physical therapist prescribed an exercise program to aid in reduction of her upper body pain, but she has not followed through on that program. She does do a series of stretching exercises on a regular basis. However, there is not sufficient evidence in the record to determine whether these stretching exercises are an adequate substitute for the exercises prescribed by her physical therapist.

Claimant was earning an annual salary of $21,445 when she last worked for the employer in July 1985. As a result of her compensable injuries, she is no longer able to perform most of her previous medium-level jobs with the employer. She currently works as a medial receptionist and also has the skills necessary for employment as a dental assistant. Those jobs pay a monthly wage of $850 to $1,170. She also has some training as a computer operator, a phlebotomist and an x-ray technician. She needs further training in order to be employable in the latter two positions.

At the time of the hearing, claimant had received 5 percent scheduled permanent disability for each forearm, and 5 percent unscheduled permanent disability for her back condition.

FINDINGS OF ULTIMATE FACT

Claimant has suffered permanent wrist and hand impairment as a result of her compensable injuries. This impairment has resulted in 10 percent loss of use or function of her left forearm, and 20 percent loss of use or function of her right forearm.

Claimant has also suffered mild physical impairment in her mid and low back and minimal impairment in her neck. this impairment has resulted in a loss of earning capacity of 15 percent.

CONCLUSIONS OF LAW AND OPINION

Admissibility of Evidence

We affirm and adopt the Referee's ruling on the evidentiary issue.

Permanent Scheduled Disability

The Referee affirmed a Determination Order award of 5 percent scheduled permanent disability for each forearm. Claimant contends that she is entitled to an additional award of scheduled disability. We agree.

Claimant testified to frequent sharp, disabling pain in her right wrist, and similar disabling pain in her left wrist on a less frequent basis. She stated that her pain is associated with typing for more than one or two hours, putting weight on her hands, bending her wrists backward and lifting ore than 20 pounds. She also testified to right hand grip loss which causes her to drop items at least once a day.

The record contains impairment ratings from four medical experts. Claimant's treating hand surgeon, Dr. Jewell, opined that claimant had 10 percent impairment in her right hand, and on unspecified degree of impairment in her left hand. Treating neurologist Randle opined that claimant had mild impairment. Dr. Nathan, hand surgeon, and Dr. Zivin, neurologist, both rated claimant's impairment as minimal.

We have several problems with the Referee's analysis of this record. First, she noted that claimant exhibited minimal carpal tunnel symptoms at examinations on December 11, 1985 and August 25, 1987. However, these examinations did not involve the type of strenuous and repetitive activity associated with claimant's disabling wrist and hand flare-ups. The Referee also relied on the fact that claimant had not received treatment for her wrist and forearms since December 1985. We note that treatment history is only one factor to be considered in rating permanent impairment.

Most importantly, the Referee did not consider claimant's testimony, noting that her complaints varied with her "mood or mental condition" and were not consistent with Dr. Randle's December 1985 description of her physical capabilities. Unlike the Referee, we are not persuaded that any part of claimant's residual wrist and hand disability is psychological in nature. Her fibrositis condition does have a psychological component, but that condition is referable to claimant's neck and back, only. Further, the record indicates that her sleep and mood disorder resolved prior to hearing. The disorder was much improved when Dr. Randle examined her in December 1985, and treatment was apparently terminated in the Spring of 1986. There is no evidence that her disorder continued after that time. Her present sleep disruption is due to her back pain, not any separate sleep and mood disorder.

Even if we were to assume that some portion of claimant's wrist and hand pain is psychological in nature, we would still disagree with the Referee's analysis. We have previously concluded that claimant's fibrositis condition and sleep and mood disorder are compensable. See Karol K. Wood, 40 Van Natta 1989 (1988). Hand and wrist impairment attributable to those conditions should, therefore, be considered in awarding scheduled disability. See Mesa v. Barker Manufacturing Co., 66 Or App 161 (1983); Scheidemantel v. SAIF, 70 Or ap 552 (1984); Carol L. Smith, 35 Van Natta 1294 (1983). Furthermore, claimant's

testimony should be considered in rating her physical impairment absent persuasive evidence that she voluntarily exaggerates her symptoms and limitations. See Barrett v. Coast Range Plywood, 294 Or 641 (1983); Elliott v. Precision Castparts Corp., 30 Or App 399 (1977).

We are not persuaded that claimant voluntarily exaggerates her disability. The medical experts have opined, without exception, that her pain is real to her. Her testimony is consistent with her well-documented history of increased wrist pain and grip loss with strenuous and repetitive activity. We do not agree with the Referee's view that claimant's testimony is inconsistent with the impairment reported by Dr. Randle in December 1985. Claimant testified that when working as a bartender she could not lift wine kegs up onto overhead racks. She also stated that she made extra trips to clear tables or deliver ice in order to avoid carrying heavy loads. That testimony is not significantly different from Dr. Randle's statement that claimant was able to perform her bartending job with only occasional mild aching pain in her wrists and palms after she did extensive carrying of heavy objects.

Accordingly, we consider claimant's testimony in rating her permanent wrist and hand disability. We evaluate her testimony, along with the documentary record, in light of the guidelines set forth at former OAR 436-35-080 and 436-35-110. Based on our evaluation, we conclude that claimant has sustained 10 percent loss of use or function of the left forearm and 20 percent loss of use or function of the right forearm.

Permanent Unscheduled Disability

The Referee affirmed a Determination Order award of 5 percent unscheduled permanent disability for claimant's neck and back condition. Claimant contends that she is entitled to an additional award of unscheduled disability. We agree.

In April 1984, Dr. Rosenbaum, neurosurgeon, indicated that claimant would have regular neck and back flare-ups if she continued her strenuous job with the employer. In December 1985, treating physician Randle reported that claimant had mild residual dysfunction in her neck and shoulders. Dr. Zivin examined claimant more recently in August 1985, reporting a 15 percent loss in lumbar flexion due to disabling pain in the mid and low back. He opined that claimant has sustained minimal impairment as a result of her residual neck and back pain. Claimant testified to constant restricted forward bending, nightly sleep interruption due to back pain, and periodic flare-ups of disabling neck and back pain. She experiences flare-ups when she stays in one position too long, performs repetitive bending, lifts more than 20 pounds, or lifts even that amount on a regular basis.

Once again, the Referee did not consider claimant's testimony in rating her unscheduled impairment. We have previously discussed why that testimony should be considered in rating scheduled impairment. Consistent with that discussion, we conclude that claimant's testimony should also be considered in rating her unscheduled disability. Based on her testimony and the opinions of the medical experts, we find that claimant has sustained mild physical impairment in her mid and low back and minimal impairment in her neck.

We consider this degree of physical impairment in light of the social and vocational factors set forth in former OAR 436-30-380 et seq. Claimant, a high school graduate, was 34-years old at the time of hearing. She is unable to perform many of her former, medium-level jobs with the employer. She currently works as a medical receptionist, and is also employable as a dental assistant. Those positions pay around $12,000 a year, whereas claimant was earning over $21,000 a year at the time of her injury. Her inability to perform her prior jobs with the employer is partially attributable to her wrist and hand impairment, for which she has been separately compensated. She has not demonstrated that she followed the exercise recommendation of Dr. Randle and her physical therapist. See Sarantis v. Sheraton Corp., 69 Or app 575,577 (1984).

After considering these factors, we conclude that a total award of 15 percent unscheduled permanent partial disability adequately compensates claimant for her neck and back condition.

ORDER

The Referee's order dated October 28, 1987 is affirmed in part and modified in part. Claimant is awarded an additional 5 percent (7.5 degrees) scheduled permanent disability for the left forearm, an additional 10 percent (15 degrees) scheduled disability for the right forearm, and an additional 10 percent (32 degrees) unscheduled disability for her neck and back condition. The remainder of the Referee's order is affirmed. Claimant's attorney is entitled to an approved fee equal to 25 percent of the increased compensation awarded under this order. The Board approves a client-paid fee, not to exceed $700.

JAMES C. BOND, Claimant
SAIF Corp, Insurance Carrier

Own Motion 89-0450M
September 27, 1989
Own Motion Order

The SAIF Corporation has submitted to the Board claimant's claim for an alleged worsening of his August 31, 1955 industrial injury. Claimant is requesting that his claim be reopened for replacement of his elbow prosthesis. Claimant's aggravation rights have expired. SAIF recommends that the Board reopen claimant's claim for the requested medical service.

In cases involving pre-1966 injury claims, as here, we may exercise our "own motion" authority to reopen a claim for payment of additional medical benefits. ORS 656.278(1)(b). After reviewing the record in this case, we conclude that claimant's claim should be reopened for provision of a new elbow prosthesis. SAIF should then reclose the claim under OAR 438-12-055. Reimbursement from the Reopened Claims Reserve is authorized to the extent allowed under ORS 656.625 and OAR 436, Division 45.

IT IS SO ORDERED.

FRED W. BRICKLEY, Claimant
SAIF Corp, Insurance Carrier

Own Motion 89-0393M
September 27, 1989
Own Motion Order

SAIF Corporation has submitted to the Board claimant's claim for additional medical benefits related to his October 20, 1953 injury. Claimant's aggravation rights have expired. Claimant is requesting reopening of his 1953 injury claim for surgery on his right knee and provision of a new right knee prosthesis. SAIF Corporation has recommended reopening of the claim.

In cases involving pre-1966 injury claims, as here, we may exercise our "own motion" authority to reopen a claim for payment of further medical benefits. ORS 656.278(1)(b). We may also authorize temporary disability compensation if he has experienced a worsening of his injury requiring either inpatient or outpatient surgery or other treatment requiring hospitalization. ORS 656.278(1)(a). However, claimant is not entitled to additional temporary disability compensation unless the worsening results in lost wages. Cutright v. Weyerhaeuser Company, 299 Or 290 (1985).

Here, claimant acknowledges that he has retired from the workforce. He, therefore, has no lost wages and is not entitled to temporary disability compensation. However, we conclude that claimant's claim should be reopened for medical treatment commencing March 27, 1989, for surgery on his right knee and provision of a new right knee prosthesis. After provision of these services, SAIF Corporation should immediately close the claim pursuant to OAR 438-12-055. Reimbursement from the Reopened Claims Reserve is authorized to the extent allowed under ORS 656.625 and OAR 436, Division 45.

IT IS SO ORDERED.

ROGER D. JOBE, Claimant
Philip H. Garrow, Claimant's Attorney
SAIF Corp Legal, Defense Attorney

Own Motion 89-0285M
September 27, 1989
Own Motion Order

The SAIF Corporation has submitted to the Board claimant's claim for an alleged worsening of his June 4, 1981, industrial injury. Claimant's aggravation rights have expired. SAIF has accepted responsibility for claimant's current condition and resulting need for treatment, but it opposes claim reopening for temporary disability benefits on grounds that claimant's compensable injury has not worsened and that his hospitalizations have been for conservative care.

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

The record shows that claimant was hospitalized twice for low back pain, on November 16, 1988, and from December 1 through December 5, 1988. Claimant was treated conservatively on both occasions. On November 16, 1988, claimant was admitted to the

hospital emergency room for x-rays and medication. He apparently was discharged that same day. On December 1, 1988, claimant was again admitted to the hospital for further x-rays and medication. In addition to low back pain, claimant was diagnosed with depression, for which he participated in extensive family counseling with his wife. Claimant was discharged after four days of hospitalization. Following our review of this record, we are not persuaded that claimant's hospital stay on November 16, 1988, rises to the level of "hospitalization" required for the Board to exercise its own motion authority under ORS 656.278(1)(a). We are persuaded, however, that the four-day hospital stay in December, 1988, does qualify for own motion relief. That stay was directed not only toward claimant's low back condition, but also toward his depression, a new condition that evidences a worsening of claimant's original injury. Consequently, we are persuaded that claimant's compensable injury has worsened requiring hospitalization.

Accordingly, claimant's claim is reopened with temporary disability benefits to commence on December 1, 1988, the date of hospitalization, and to continue until claimant returns to his regular work at his regular wage or is medically stationary, whichever is earlier. Claimant's attorney is awarded 25 percent of the additional compensation granted by this order, not to exceed $50, as a reasonable attorney fee. Reimbursement from the Reopened Claims Reserve is authorized to the extent allowed under ORS 656.625 and OAR 436, Division 45. When appropriate, the claim shall be closed by SAIF pursuant to OAR 438-12-055.

IT IS SO ORDERED.

RALPH JOHNSON, Claimant
Rosenthal & Greene, Claimant's Attorneys
David O. Horne, Defense Attorney

WCB 87-01078
September 27, 1989
Order on Review

Reviewed by Board Members Gerner and Myers.

The insurer requests, and claimant cross-requests, review of Referee Menashe's order that granted claimant permanent total disability effective October 8, 1987, in lieu of an award of 45 percent (144 degrees) unscheduled permanent disability for a left shoulder, neck, and groin injury as previously awarded by a Determination Order. The issues on review are extent of disability, including permanent total disability, the effective date of permanent total disability, and offset. We affirm as modified.

CONCLUSIONS OF LAW AND OPINION

We adopt the findings of fact and opinion of the Referee with the following modification:

The Referee found claimant to be permanently and totally disabled as of the date of the hearing. On review, claimant argues that the effective date should be August 19, 1986. We agree. In Morris v. Denny's, 53 Or App 863 (1981), the court indicated that when a permanent total disability award is determined, the effective date of that determination is the earliest date that claimant's permanent total disability is proved to exist. See also, Adams v. Edwards Heavy Equipment Inc., 90 Or App 365 (1988). Claimant urges that this date should be the date Dr. Snodgrass opined that claimant was medically stationary and permanently disabled. The insurer expresses no opinion on the proper date, but

requests the right to offset any payment of permanent partial disability paid earlier if the effective date is found to be earlier than that found by the Referee.

We agree that claimant's permanent total disability was established on August 19, 1986. However, our review of the record reveals no request below for offset. In Elsie L. Hobkirk, 40 Van Natta 778 (1988), we denied a similar request because this issue was not raised below. The "raise or waive" rule cited in Wilson v. SAIF, 48 Or App 953 (1980) applies to requests for offset, even if the litigation is not complete. We hold that because no issue of offset was raised before the Referee, the issue has been waived. Accordingly, we deny the request to offset previously paid permanent partial disability against the award of permanent total disability.

ORDER

The Referee's order dated November 4, 1987, is affirmed, as modified. The effective date for payment of claimant's permanent total disability shall be August 19, 1986. The insurer's request to offset these permanent total disability benefits against previously paid permanent partial disability benefits is denied. Claimant's attorney is awarded an assessed fee of $1,200, to be paid by the insurer.

LEO KENNEDY, Claimant
Helm, et al., Claimant's Attorneys
SAIF Corp Legal, Defense Attorney

Own Motion 88-0246M
September 27, 1989
Own Motion Order on Reconsideration

Claimant's attorney has requested approval of an attorney fee for services culminating in the Board's July 18, 1989 Own Motion Order. In that order, the Board reopened claimant's pre-1966 injury claim for medical services, only.

Under OAR 438-15-080, the Board may only authorize attorney fees in own motion matters when it has increased compensation for temporary disability. Here, the Board awarded medical services, rather than temporary disability compensation. Accordingly, we are without authority to approve the requested attorney fee, and the request is hereby denied.

IT IS SO ORDERED.

GARY G. LEGLER, Applicant
Thomas J. Dzieman, Assistant Attorney General

WCB CV-89001
September 27, 1989
Order on Reconsideration
(Crime Victim Act)

On September 18, 1989, applicant requested reconsideration of the special hearings officer's proposed order issued September 13, 1989. Applicant expressed dissatisfaction with the special hearing officer's factual findings and conclusions.

After conducting our review of this case, we agree with the findings and conclusions contained in the proposed order of the special hearings officer. Therefore, the proposed order is

affirmed in its entirety. Accordingly, this matter is final by operation of law. ORS 147.155; OAR 438-82-050(1), (2). There is no further right of appeal. Id.

IT IS SO ORDERED.

FINDINGS OF FACT,
CONCLUSIONS AND PROPOSED
ORDER (CRIME VICTIM ACT)

Pursuant to notice, a hearing was conducted and concluded by James W. Moller, special hearings officer, on August 28, 1989 at Medford, Oregon. Applicant, Gary G. Legler, was present and not represented by counsel. The Department of Justice Crime Victims' Compensation Fund ("Department") was represented by Thomas Dzieman, Special Assistant Attorney General. The hearing reporter was Sandy Chapman. The record was closed August 28, 1989.

Applicant has requested review by the Workers' Compensation Board of the Department's Findings of Fact, Conclusions and Order on Reconsideration dated February 24, 1989. By its order, the Department denied applicant's claim for compensation, filed pursuant to the Compensation of Crime Victims Act (Act). ORS 147.005 to 147.365. The Department based its denial on a finding that claimant had not established that he was the victim of a compensable crime. In addition, the Department argued at hearing that claimant did not suffer serious bodily injury; that claimant had been fully compensated for his injuries through the workers' compensation system; and that claimant's exclusive remedy was pursuant to the workers' compensation laws.

I conclude that applicant was the victim of a compensable crime, and that he is not limited to recovery under the workers' compensation laws. However, ORS 147.125(4) provides that any "benefits, payments or awards" from any source received by the victim as a result of his injuries shall be deducted from the compensation otherwise due to him under the crime victim compensation statute. Because applicant has received such payments in excess of his compensable losses, I conclude that he is entitled to no recovery.

ISSUES

Is applicant limited to benefits under the Workers' Compensation Law as his exclusive remedy?

Was applicant the victim of a compensable crime? Did applicant suffer "serious bodily injury"?

Has applicant been fully compensated for his injuries under the Workers' Compensation Law?

FINDINGS OF FACT

The following facts are not in dispute. On June 19, 1987, applicant was employed as a forklift driver. During the course of his work shift, applicant had moved several units of pine from the sawmill to an outside area to air dry. He was bringing an additional load to the same site, when he encountered a co-worker, Charles Reeves. Reeves informed applicant that applicant was placing the wood in the wrong area. Reeves stated that the wood was to be kiln-dried rather than air-dried.

Applicant responded that he had been instructed by his supervisor to place the wood in the open-air area. Reeves disagreed with this instruction. An argument ensued over whether applicant was required to follow Reeves' instructions, i.e. whether Reeves was applicant's supervisor in this matter.

At this time, Reeves rested several "stickers" against the unit of wood held on applicant's forklift. These stickers are 4 by 4 pieces of wood approximately 25 inches in length. Applicant responded by raising the unit on his forklift so that the stickers fell to the ground. These stickers fell haphazardly onto other stickers which had previously been placed on the ground. Applicant then lowered the unit onto the stickers and began to back away from the unit. Reeves objected to applicant leaving the unit in such a fashion. Reeves jumped on the running board of the forklift. A struggle ensued.

During the course of the struggle, Reeves' glasses fell to the ground. Also during the course of the struggle, Reeves grabbed applicant around the neck and forced him off the seat of the forklift and down between the motor cover and the roof bar support.

Following the struggle, Reeves climbed down from the forklift and began searching for his glasses. Meanwhile, applicant left his forklift and went to report the incident.

Applicant was examined later that day at the Rogue Valley Medical Center, where he was treated for right flank pain and neck pain. The diagnosis was acute cervical and thoracic strain. A cervical collar was applied which claimant continued to wear for the next several months.

The incident occurred on a Friday. Both applicant and Reeves were suspended from work over the ensuing weekend. When applicant returned to work on Monday, he was fired. Reeves continued to work for the employer as of the date of hearing.

On Monday, June 22, 1987, claimant went to the District Attorney's office. He was referred to the Central Point Police Department. Applicant reported the incident to the Central Point Police Department. Officer Newell, a Central Point police officer, investigated the incident. Officer Newell took the statements of both applicant and Reeves. The final police report of the incident was sent to the District Attorney's office. The District Attorney elected not to file any charges against Reeves.

Applicant had experienced two prior work-related injuries. On November 11, 1984, applicant injured his low back while working for the employer. On March 8, 1986, applicant injured his neck while working for the employer. As a result of these prior injuries, claimant was receiving continuing chiropractic treatments from Dr. Kelty at the time of the June 19, 1987 incident.

Subsequent to the June 19, 1987 incident, applicant filed a workers' compensation claim. The claim was denied by the employer's insurer on August 19, 1987. Claimant also filed an aggravation claim with the workers' compensation insurer on the risk at the time of his prior work injuries. This claim was also denied. The parties subsequently entered into a disputed claim

settlement agreement whereby applicant dismissed his hearing requests concerning each of these denials in return for payments totalling $12,000. (Ex. 15). One of the insurers had also paid $2,340.61 in interim compensation benefits pending issuance of its denial. (Ex. 7).

In addition to the above undisputed findings, I make the following findings.

Neither applicant nor Reeves is entirely credible in their account of the June 19, 1987 incident. I find in this regard that applicant did shove the palm of his hand under Reeves' chin when Reeves jumped onto the forklift. In making this finding, I note that Reeves' statements to this effect are consistent throughout the record. Moreover, this is the most reasonable explanation for how Reeves' glasses became dislodged and ended up underneath the forklift.

However, contrary to Reeves' testimony at hearing, I find that applicant did not place his hands around Reeves' throat at any time. No such assertion appears in any of the contemporaneous reports. Further, applicant credibly denied having done so.

In addition, I find that Reeves did strike claimant in the back and right hip with either his fists or his knee during the incident. I rely in this regard upon the fact that claimant reported to the hospital emergency room with right flank pain which cannot reasonably be attributed to any other explanation of the incident. (Ex. 12). I also found Reeves' demeanor while denying such acts to be overly-dramatic and not sincere.

Finally, I find that applicant has incurred compensable losses as a result of this incident in the amount of $1,182.79. (Ex. 21-5).

FINDINGS OF ULTIMATE FACT

Applicant experienced serious bodily injury as a result of the June 19, 1987 incident.

Claimant has received payments or awards from other sources totalling $14,340.61 as a result of his injuries. This sum exceeds the total of his compensable losses.

CONCLUSIONS OF LAW AND OPINION

Workers' Compensation as Exclusive Remedy

The Department argued at hearing that applicant's exclusive remedy is pursuant to the Workers' Compensation Laws. ORS 656.001 et. seq. In this regard, the Department apparently relies upon ORS 656.018(1)(a), which states, in part:

> "The liability of every employer who satisfies the duty required by ORS 656.017(1) is exclusive and in place of all other liability arising out of compensable injuries to the subject workers * * *."

Applicant is seeking recovery not from the employer, but instead from the Criminal Injuries Compensation Fund. Consequently, ORS 656.018 has no application here.

Compensable Crime

The Department's order denying compensation benefits to applicant was premised upon applicant's failure to establish the commission of a "compensable crime." A "compensable crime" is defined by ORS 147.005(4):

> "'Compensable crime' means an intentional, knowing or reckless act that results in serious bodily injury or death of another person and which, if committed by a person of full legal capacity, would be punishable as a crime in this state."

The Department's conclusion that claimant failed to establish a compensable crime was apparently based, in part, upon the district attorney's election not to prosecute Reeves for assault. The question raised, therefore, is whether an applicant is entitled to benefits only where charges have been brought against the alleged perpetrator of the crime.

The fact that an alleged assailant has been charged with a crime is certainly evidence of the occurence of a compensable crime. See ORS 147.305 (conviction of crime based on compensable crime is conclusive evidence that crime was committed). However, the statute does not expressly require that an applicant prove that charges have been brought in order to recover compensation. In this regard, charges may not be brought for a number of reasons independent of whether a crime was committed. For example, the perpetrator of the crime may not be known. Similarly, criminal charges may not be brought against a suspected assailant due to a lack of sufficient evidence to establish guilt beyond a reasonable doubt. And yet, an applicant may still be capable of establishing that he has been the victim of a compensable crime as defined in the statute. I conclude that the statute does not require commencement of prosecution as a prerequisite to recovery of benefits. Therefore, I disagree with the Department's decision insofar as it denied benefits based upon the fact that the District Attorney declined to bring charges.

The next question is whether the June 19, 1987 incident resulted in "serious bodily injury" to applicant as that phrase is used in ORS 147.005(4). Chapter 147 does not contain a definition of "serious bodily injury." The Department argues that guidance can be found in the criminal code. Although the criminal code does not contain a definition for "serious bodily injury," it does present a definition for "serious physical injury." That definition is found at ORS 161.015(7), which provides:

> "(7) 'Serious physical injury' means physical injury which creates a substantial risk of death or which causes serious and protracted disfigurement, protracted impairment of health or protracted loss or impairment of the function of any bodily organ."

Applicant was treated at the hospital emergency room on the day of the incident. The diagnosis at that time was acute cervical and thoracic strain. He was released from work for five days, and a soft cervical collar was applied. Applicant continued

to wear the cervical collar for several months. Applicant also treated with Dr. Kelty following the incident. Although he was treating with Dr. Kelty before the incident, his frequency of treatment increased following the incident. Dr. Kelty subsequently reported that applicant would likely experience continuing pain as a result of the incident, and that some of his injuries might be permanent.

Applying the legal standard advanced by the Department, the above unrebutted evidence supports a finding that applicant experienced "serious and protracted impairment of health" as a result of his injuries. I, therefore, conclude that applicant did experience "serious bodily injury" as a result of the June 19, 1987 incident.

Accordingly, applicant has proven that he was the victim of a compensable crime as defined in Chapter 147 of ORS.

Applicant's Receipt of Workers' Compensation Benefits

The Crime Victim Compensation law provides that an applicant's compensation shall be reduced by "the amount of benefits, payments or awards, payable under the Workers' Compensation Law * * * or from any source, and which the victim [has] received * * * as a result of the * * * injury." ORS 147.125(4). The Department contends that applicant has been fully compensated for his injuries as a result of the Disputed Claim Settlement entered into on his workers' compensation claims.

In this regard, applicant alleges compensable expenses of $1,182.79. In addition to $2,340.61 of time loss benefits, applicant received $12,000 pursuant to the disputed claim settlement. Although applicant argued at hearing that the settlement agreement was unrelated to the June 19, 1987 incident, the agreement itself indicates otherwise. The agreement provides, in part:

> "On June 19, 1987, [applicant] and a coworker were involved in an altercation on the premises of the employer, Cornett Lumber Company. * * *. [Applicant] suffered injuries to his neck, mid-back, low back, right hip, cervical spine, thoracic spine, lumbar spine, and ribs.
>
> "[Applicant] contends that his June 1987 injuries arose out of and in the course of his employment or were aggravations of his previously accepted injuries. * * *.
>
> "The employer, through its insureds, denies that claimant's injuries arose out of and in the course of [applicant's] employment or were aggravations of previously accepted injuries. * * *.
>
> "There is a bona fide dispute between the parties about the compensability of [applicant's] conditions. The parties have agreed to settle [applicant's] claim pursuant to ORS 656.298(4) by this DISPUTED

CLAIM SETTLEMENT. The parties agree that TWELVE THOUSAND DOLLARS is a reasonable settlement amount to settle all claims."

I conclude that the agreement directly resulted from applicant's claims arising out of the June 19, 1987 incident. Accordingly, payments received by applicant pursuant to the settlement agreement are a result of the compensable injuries. Because applicant has received payments far in excess of his compensable expenses, he is entitled to no recovery.

In sum, applicant has proven that he was a victim of a compensable crime. However, applicant has received payments for his compensable injuries which exceed the amount of compensation to which he would otherwise be entitled. Therefore, applicant is entitled to no recovery. ORS 656.147.125(4).

PROPOSED ORDER

I recommend that the Findings of Fact, Conclusions and Order on Reconsideration of the Department of Justice Crime Victims' Compensation Fund dated February 24, 1989 be reversed insofar as it found that applicant was not the victim of a compensable crime. I further recommend that the Department's order be affirmed insofar as it concluded that applicant is entitled to no recovery of benefits.

HERMAN LOVAN, Claimant
Emmons, et al., Claimant's Attorneys
SAIF Corp Legal, Defense Attorney

Own Motion 87-0546M
September 27, 1989
Second Own Motion Determination

Claimant's counsel requests Board authorization of an attorney fee, payable out of compensation, for services rendered before the Board which culminated in our July 18, 1989, Own Motion Determination, which closed claimant's claim with awards of temporary total and permanent total disability benefits. Specifically, counsel seeks a $500 fee payable out of claimant's award of permanent total disability (PTD). Additionally, the SAIF Corporation requests both authorization for an offset of overpaid temporary disability benefits and designation of the date on which claimant's PTD award became effective.

After reviewing the statement of services submitted by claimant's counsel and considering the factors set forth in OAR 438-15-010(6), we award 25 percent of claimant's permanent total disability benefits, not to exceed $500, as a reasonable attorney fee.

In our original Own Motion Determination we found that claimant became medically stationary on September 29, 1988, and awarded him temporary disability benefits through that date. Therefore, SAIF may offset any temporary disability benefits paid after that date against claimant's PTD award.

Claimant was awarded PTD based on the "odd-lot" doctrine, i.e., based on consideration of both his physical condition and certain social and vocational factors, including age, education and prior work experience. An award of PTD under the odd-lot doctrine is effective as of the earliest date that all relevant medical, social and vocational elements exist to support the award. Adams v.

Edwards Heavy Equipment, Inc., 90 Or App 365, 370-71 (1988); Morris v. Denny's, 50 Or App 533, mod 53 Or App 863, 867 (1981). Here, Dr. Lumsden, the treating physician, declared claimant "permanently disabled from all occupations" on September 29, 1988. Based on that report, we find that all elements supporting the PTD award existed on September 29, 1988. Accordingly, claimant's PTD award is effective as of that date.

IT IS SO ORDERED.

BEN F. NOCK, Claimant
SAIF Corp, Insurance Carrier

Own Motion 89-0526M
September 27, 1989
Own Motion Order

SAIF Corporation has submitted to the Board claimant's claim for additional medical benefits related to his September, 1943 injury. Claimant's aggravation rights have expired. Claimant is requesting reopening of his 1943 injury claim for the purchase of replacement socks and waist belts for his below-the-knee amputation. SAIF Corporation has accepted responsibility for the claimant's current need for medical benefits and recommends reopening of the claim.

In cases involving pre-1966 injury claims, as here, we may exercise our "own motion" authority to reopen a claim for payment of further medical benefits. ORS 656.278(1)(b). After review of the record, we conclude that claimant's claim should be reopened for the purchase of the requested medical services. After provision of these services, SAIF Corporation should immediately close the claim pursuant to OAR 438-12-055. Reimbursement from the Reopened Claims Reserve is authorized to the extent allowed under ORS 656.625 and OAR 436, Division 45.

IT IS SO ORDERED.

RAYMOND R. RIEKE, Claimant
Karen M. Werner, Claimant's Attorney

Own Motion 89-0429M
September 27, 1989
Own Motion Order

Claimant requests review of the self-insured employer's June 9, 1989, Notice of Closure, which terminated temporary disability benefits as of October 10, 1988. Additionally, the employer seeks Board authorization of reimbursement from the Reopened Claims Reserve for temporary disability benefits paid after voluntarily reopening this claim.

A claim reopened under the Board's "own motion" authority may be closed without issuance of a Board order if medical reports indicate to the insurer or employer that claimant's condition has become medically stationary. OAR 438-12-055(1). Here, the record is devoid of any medical report indicating that claimant was medically stationary at the time of claim closure. Dr. Lundsgaard, claimant's treating physician, last examined claimant in December, 1988, and declared him not yet medically stationary. There is no record of any further examinations. Therefore, based on this record, we do not find that claimant was medically stationary at the time of claim closure. Accordingly, the employer's June 9, 1989, Notice of Closure is set aside and the claim is remanded for further processing. When appropriate, the claim shall be closed by the employer pursuant to OAR 438-12-055.

Regarding the employer's reimbursement request, we find that claimant's compensable injury has worsened requiring surgery on April 20, 1988. Accordingly, reimbursement from the Reopened Claims Reserve is authorized to the extent allowed under ORS 656.625 and OAR 436, Division 45.

IT IS SO ORDERED.

GEORGE O. VOSHELL, Claimant
Peter O. Hansen, Claimant's Attorney
SAIF Corp Legal, Defense Attorney

Own Motion 87-0108M
September 27, 1989
Order Postponing Action on Own Motion Request

The SAIF Corporation initially submitted to the Board claimant's claim for an alleged worsening of his August 1976 industrial injury. Claimant's aggravation rights have expired. The Board postponed action on claimant's request pending resolution of WCB Case No. 87-04204. That litigation was finally resolved by stipulation, approved August 24, 1987. The Evaluations Division then closed the claim by Determination Order, issued June 5, 1989, following claimant's participation in a vocational assistance program. Claimant appealed that Determination Order, and the matter is currently pending before the Hearings Division in WCB Case No. 89-10999.

It is the Board's policy to postpone any decision regarding own motion relief until such time as relevant pending litigation is resolved. Therefore, we continue to delay action on this own motion matter and request that the Referee who conducts the hearing in WCB Case No. 89-10999 submit a copy of his/her order to the Board. After issuance of that order, the parties should advise the Board of their respective positions regarding own motion relief.

IT IS SO ORDERED.

J.C. WARREN, Claimant
SAIF Corp, Insurance Carrier

Own Motion 89-0221M
September 27, 1989
Own Motion Order

The SAIF Corporation has submitted to the Board claimant's claim for an alleged worsening of his August 26, 1965 injury. Claimant's aggravation rights have expired. Claimant is requesting reopening of his claim for provision of the following medical services: (1) medication on an ongoing basis to control claimant's compensable respiratory condition; (2) other medical services provided for an October 1988 flare-up of that condition, including doctor visits on October 12 and 13, 1988 and laboratory work performed on November 18, 1988; and (3) emergency room care provided on April 2, 1989. SAIF has recommended that the Board authorize the requested medical services.

In cases involving pre-1966 injury claims, as here, we may exercise our "own motion" authority to reopen a claim for payment of further medical benefits. ORS 656.278(1)(b). After review of the record, we are persuaded that claimant requires the requested ongoing medication to remain medically stationary. We further conclude that payment for the other medical services requested by claimant would be appropriate.

Accordingly, claimant's claim is reopened for payment of

the requested medical benefits. We hereby direct SAIF to pay for claimant's medication on a continuing basis pursuant to ORS 656.278(1)(b). We also direct SAIF to pay for emergency room care rendered on April 2, 1989, and medical services provided at the time of claimant's exacerbation in October 1988. Reimbursement of these expenses from the Reopened Claims Reserve is authorized to the extent allowed under ORS 656.625 and OAR 436, Division 45. Payment for future periodic doctor visits, emergency room care and laboratory work may be allowed as the need arises upon request to the Board. However, we will require medical documentation of these periodic expenses.

IT IS SO ORDERED.

DAVID L. WHITLOW, Claimant
Robert H. Grant, Claimant's Attorney
Cowling & Heysell, Defense Attorneys

WCB TP-89019
September 27, 1989
Third Party Partial Distribution Order

Claimant has petitioned the Board for resolution of a conflict concerning the "just and proper" distribution of proceeds from a third party settlement. See ORS 656.593(3). Specifically, the dispute concerns the paying agency's entitlement to a lien for anticipated future medical expenditures. ORS 656.593(1)(c), (d). We conclude that the paying agency has established that it is reasonably certain that it will incur such expenditures.

FINDINGS OF FACT

We adopt the findings of fact as set forth in our December 7, 1988 Third Party Partial Distribution Order. See David L. Whitlow, 40 Van Natta 1980 (1988). Pursuant to our prior order, we held that the paying agency was entitled to $6,039.29 of the $10,784.51 remaining balance of claimant's third party settlement as reimbursement for its actual claim costs. Inasmuch as claimant's permanent disability had not been finally determined, we deferred consideration of the paying agency's lien for its future claim costs. Upon final determination of the permanent disability issue, the parties were requested to notify us if a dispute continued to exist concerning the $4,745.22 remaining balance.

On February 23, 1989, the Board affirmed a Referee's order, which had awarded claimant 20 percent unscheduled permanent disability for a low back injury. That order has become final by operation of law. The parties have been unable to resolve their dispute concerning the distribution of the remaining proceeds from the third party settlement.

Claimant's compensable condition is diagnosed as a herniated nucleus pulposus at L5-S1. Surgery is not considered necessary nor does claimant desire it. He last sought medical treatment in October 1986. However, it is reasonably anticipated that he will need intermittent physical therapy with manipulation and other modalities, probably on the frequency of 10 visits per year on a long term basis.

Claimant is approximately 42 years of age. Chiropractic treatments for his low back condition cost $43 per visit.

CONCLUSIONS OF LAW

After the deduction of attorney fees, litigation costs, and claimant's statutory 1/3 share, the paying agency shall be paid and retain the balance of the recovery to the extent that it is compensated for its expenditures for compensation, first aid or other medical, surgical or hospital service, and for the present value of its reasonably to be expected future expenditures for compensation and other costs of the worker's claim under ORS 656.001 to 656.794. See ORS 656.593(1)(c). Such other costs do not include any compensation which may become payable under ORS 656.273 or 656.278. id. To support its lien for anticipated future expenditures, the paying agency must establish that it is reasonably certain to incur such expenditures. Donald P. Bond, 40 Van Natta 361, 480 (1988); Leonard Henderson, 40 Van Natta 31 (1988).

Here, the paying agency has not received a bill for medical treatment concerning claimant's 1983 compensable injury since October 1986. Furthermore, claimant's counsel asserts that claimant has no intention of seeking future medical services. Yet, the medical experts offer a different perspective.

Dr. Colwell, claimant's treating chiropractor, predicts that, without surgery, claimant will need 6 to 8 monthly treatments. Dr. Dunn neurosurgeon, concurs that future conservative treatments will be necessary. Concluding that claimant will need intermittent physical therapy with manipulation and other modalities, Dr. Dunn, anticipates treatments on a long term basis over a period of a number of years probably on the frequency of 10 to 20 visits per year. Although Dr. Dunn does not indicate what the cost of a treatment would be, Dr. Colwell lists the cost at $43 per visit.

As previously noted, claimant has apparently not sought medical treatment since October 1986. Such evidence suggests that he has not needed care in the short-term. However, such an implication does not necessarily lead to the conclusion that future care for claimant's low back condition will not be required as the years unfold. Rather, since claimant's herniated disc condition has been objectively confirmed and considering the complexity of this medical treatment issue, we are persuaded by the opinions of claimant's treating physicians that it is reasonably certain that he will receive future conservative treatment.

Finally, given claimant's recent history, we conclude that his need for medical services will be at the lower end of his physicians' projected range. In other words, we find that it is reasonable to anticipate 10 conservative treatments per year. Dr. Colwell, the physician who has previously performed these treatments, currently charges $43 per visit. On this record, we consider this charge to be reasonable.

No evidence has been introduced considering the life expectancy for an approximately 42 year old male. In any event, it is reasonable to conclude that, at $430 per year (10 visits per year at $43 per visit), the present value of such medical expenditures over the remaining life span of such an individual would more than exceed the $4,745.22 remaining balance of the third party settlement.

Accordingly, we hold that the paying agency is entitled to a lien for the present value of its reasonably to be expected future expenditures for medical care resulting from claimant's compensable injury. Inasmuch as this lien for future expenditures exceeds the remaining balance of proceeds from the third party settlement, claimant's attorney is directed to distribute the balance to the paying agency.

IT IS SO ORDERED.

TOMMY V. ARMS, Claimant
Malagon & Moore, Claimant's Attorneys
Cummins, Cummins, et al., Defense Attorneys

WCB 87-12851
September 28, 1989
Order on Review

Reviewed by Board Members Gerner and Myers.

Claimant requests review of Referee Paulus's order that: (1) affirmed a Determination Order that awarded 30 percent (96 degrees) unscheduled permanent disability for his low back injury; and (2) authorized the self-insured employer to offset an alleged overpayment of temporary total disability compensation against future awards of permanent disability. Additionally, claimant requests that this case be remanded for further evidence taking.

ISSUES

1. Remand for further evidence taking.
2. Extent of unscheduled permanent partial disability.
3. Offset for alleged overpayment of temporary total disability compensation.

We deny claimant's request for remand. On the extent of disability issue, we affirm and adopt the Referee's order with supplemental findings of fact. We reverse on the offset issue.

FINDINGS OF FACT

Claimant has a mild low back impairment and is able to perform light work.

We do not find that claimant received any temporary total disability benefits for any period beyond April 14, 1987.

CONCLUSIONS OF LAW AND OPINION

Remand

We may remand to the Referee for further evidence taking if we determine that this case has been "improperly, incompletely or otherwise insufficiently developed or heard by the referee." ORS 656.295(5). To merit remand, claimant must establish that material evidence was unobtainable with due diligence before the hearing. Bernard L. Osborn, 37 Van Natta 1054, 1055 (1985), aff'd mem 80 Or App 152 (1986).

We conclude that the additional evidence offered by claimant is not material to the issues raised at hearing. The evidence consists of medical reports that claimant suffered several flareups of low back pain in late January, 1988, that

ultimately resulted in surgical removal of a herniated disc at L4-5. Claimant contends that those reports are relevant to the determination of claimant's permanent disability. We disagree. The extent of claimant's permanent disability is rated on the basis of conditions existing at the time of hearing. See Gettman v. SAIF, 289 Or 609, 614 (1980). The reports in dispute, on the other hand, describe events which occurred after the date of hearing and after the record was closed on January 26, 1988. They are not probative of claimant's medical condition at the time of hearing. We conclude, therefore, that this record was not "improperly, incompletely or otherwise insufficiently developed or heard" by the Referee. The request for remand is denied.

Offset

The employer has the burden of proving that it overpaid temporary total disability (TTD) benefits for which it is entitled to an offset against future awards of permanent disability. See, e.g., Earl A. Hunter, 37 Van Natta 983 (1985); Michael E. Franks, 36 Van Natta 14 (1984). The employer relies on its claim summary sheet which shows that TTD benefits were paid for the period through April 28, 1987. However, claimant testified that he did not receive TTD benefits for any period beyond April 14, 1987. The Referee was most persuaded by the documentary evidence in finding that there was an overpayment, and she authorized the requested offset. We disagree.

The claim summary sheet merely reflects that a check for the TTD benefits in question was prepared for and apparently mailed to claimant. The record is devoid of any evidence that claimant actually received the check. Claimant's testimony that he never received the benefits in question was not refuted. Moreover, the Referee made no finding regarding claimant's credibility and reliability as a witness. Absent that finding, there is no reason to discount his testimony. We conclude, therefore, that the employer has not sustained its burden of proving that it overpaid TTD benefits for any period after June 14, 1987.

Our rules provide that, if claimant requests our review on the issue of compensation for temporary or permanent disability and we award additional compensation, we shall approve an attorney fee to be paid out of claimant's increased compensation. OAR 438-15-055(1). We have previously held, however, that a modification of the amount of an employer's future offset is not equivalent to an award of additional compensation. Nonda G. Henderson, 37 Van Natta 425 (1985). Therefore, claimant's attorney is not entitled to a fee in this case.

ORDER

The Referee's order dated February 19, 1988, is reversed in part and affirmed in part. That portion of the order that authorized the self-insured employer to offset the alleged overpayment of temporary total disability compensation against future awards of permanent disability is reversed. The offset is hereby disallowed. The remainder of the Referee's order is affirmed. The Board approves a client-paid fee not to exceed $1,000.

ROBERT C. CALVIN, Claimant
Velure & Yates, Claimant's Attorneys
E. Jay Perry, Defense Attorney

WCB 87-19119
September 28, 1989
Order on Review

Reviewed by Board Members Gerner and Myers.

Claimant requests review of Referee Quillinan's order that affirmed a Determination Order that awarded no permanent unscheduled disability. We affirm.

ISSUE

Extent of unscheduled permanent partial disability.

FINDINGS OF FACT

We adopt the "FINDINGS OF FACT" portion of the Referee's order, except the finding that all of claimant's injuries due to the industrial accident on April 6, 1987, had completely resolved.

FINDING OF ULTIMATE FACT

We find that claimant did not suffer any permanent physical impairment as a result of injuries sustained in the industrial accident on April 6, 1987.

CONCLUSIONS OF LAW AND OPINION

The criterion for rating unscheduled permanent partial disability is the permanent loss of earning capacity due to the compensable injury. ORS 656.214(5). Dr. Bamforth, claimant's treating chiropractor, rated claimant's impairment due to the compensable injury as minimal to mild, based on findings of pain and muscle spasms in the middle back, neck and left shoulder and objective findings of muscle spasms. On the other hand, Dr. Schachner, the independent medical examiner, found no evidence of impairment related to the compensable injury.

Although we ordinarily give greater weight to the treating physician's opinion, see Weiland v. SAIF, 64 Or App 810, 814 (1983), we decline to do so here for the following persuasive reasons. First, at the time of impairment rating, Bamforth was not aware that claimant had been treated for neck and low back injuries sustained in another work-related accident five years earlier and that claimant continued to have neck problems prior to this industrial accident. Second, Bamforth failed to respond to Schachner's opinion that claimant has painful impingement syndrome in both shoulders which is not related to the industrial accident. Consequently, Bamforth's rating of impairment based on left shoulder complaints is questionable. Third, Bamforth based his opinion primarily on claimant's subjective complaints, in spite of evidence that claimant overexaggerates his symptoms. Schachner noted excessive functional interference and found that each of claimant's symptoms was negated by an alternative means of examination. Although Bamforth acknowledged the possibility of functional interference, he nevertheless rated claimant's impairment based in part on claimant's pain response to palpation. Contrary to Bamforth's assertion, we are not persuaded that pain response to palpation is an objective finding of impairment.

Claimant testified to numerous symptoms involving his neck, back and left shoulder. However, we do not find that testimony reliable in light of claimant's history of overexaggerating his symptoms. Furthermore, we do not find his testimony persuasive on the question of whether his symptoms, particularly those involving his neck and left shoulder, are related to this industrial accident, as opposed to the prior accident or a non-work-related condition (i.e., impingement syndrome). That question is medically complex; hence, its resolution turns largely on expert medical evidence. Uris v. Compensation Department, 247 Or 420, 426 (1967); Kassahn v. Publishers Paper Co., 76 Or App 105, 109 (1985).

We are most persuaded by Schachner's thorough and well-reasoned opinion. See Somers v. SAIF, 77 Or App 259, 263 (1986). Based on that opinion, we do not find that claimant has sustained any permanent impairment as a result of the industrial accident on April 6, 1987.

ORDER

The Referee's order dated April 4, 1988, is affirmed. The Board approves a client-paid fee not to exceed $1,107.50.

LARRY C. STEPHENS, Claimant
Vick & Gutzler, Claimant's Attorneys
Roberts, Reinisch & Klor, Defense Attorneys

WCB 87-19317
September 28, 1989
Order on Review

Reviewed by Board Members Myers and Gerner.

Claimant requests review of that portion of Referee Baker's order that upheld the insurer's denial of his current need for medical services.

The Board affirms the order of the Referee.

ISSUE

Whether claimant's 1978 compensable injury is a material contributing cause of his current need for medical services.

FINDINGS OF FACT

Claimant sustained a compensable injury to his back in March, 1978. Dr. Johnson, his treating chiropractor, diagnosed a thoracic and lumbar strain/sprain. A Determination Order closed claimant's claim in September, 1978, with no award of permanent disability. A prior Referee, Referee Nichols, approved the Determination Order by way of an Opinion and Order, dated May 30, 1979. Claimant sought no further treatment for his back, until January, 1984, when he returned to Johnson. Johnson diagnosed a chronic lumbar strain and recommended conservative treatment. In May, 1985, claimant began to treat with Dr. Flaming, an osteopath. Flaming referred claimant to Dr. Hoda, an orthopedic surgeon, who reviewed CT Scan results and diagnosed a disc herniation at L5-S1.

On December 2, 1987, the insurer denied, inter alia, claimant's current need for medical services as no longer related to his 1978 compensable injury. A few days later, claimant

returned to Dr. Hoda with increased low back pain. Hoda needed to perform further diagnostic testing to determine whether claimant's condition had "worsened" and whether surgery was required. Despite claimant's attorney's request in February, 1988, Hoda was unwilling to render an opinion concerning the etiology of claimant's then current low back condition, without diagnostic test results.

The record contains no medical opinion in support of claimant's contention that his 1978 compensable injury is a material contributing cause of his current need for medical services.

CONCLUSIONS OF LAW

An insurer must continue to pay medical services for conditions resulting from the compensable injury for such a period as the nature of the injury or process of recovery requires. ORS 656.245(1).

Here, despite finding that claimant was credible, the Referee found that claimant had failed to prove his case. We agree.

Claimant sustained a low back strain in March, 1978. His injury apparently resolved one-half year later and he went without further medical treatment until 1984. At that time, he was thought to still suffer from only a strain; albeit chronic. A disc herniation was not suspected until June, 1985.

In addition to these facts, the record in this case contains no medical opinion establishing that the original compensable injury was a material contributing cause to the current need for treatment. Considering the absence of treatment for approximately five years, the new diagnosis of a disc herniation, and the lack of expert medical opinion on the issue of causation, the evidence does not preponderate in favor of compensability.

Accordingly, we agree with the Referee and conclude that claimant's 1978 compensable injury is not a material contributing cause of his current need for medical services.

ORDER

The Referee's order, dated March 30, 1988, is affirmed. The Board approves a client-paid fee, payable from the insurer to its attorney, not to exceed $1,030.

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

WCB 86-02639
September 29, 1989
Order on Remand

This matter is before the Board on remand from the Court of Appeals. Brannon v. Multnomah Plywood Corp., 92 Or App 99 (1988). We have been instructed to reconsider this case in light of Armstrong v. Asten-Hill Co., 90 Or App 200 (1988) and Johnston v. James River Corp., 91 Or App 721 (1988). We proceed with our reconsideration.

The insurer requests review of Referee Fink's order that

set aside its denial of claimant's occupational disease claim relating to his low back. On reconsideration, the issue is compensability. We affirm the order of the Referee.

FINDINGS OF FACT

Claimant first injured his low back in 1964 in the course of his employment with a Washington employer. That injury ultimately resulted in the surgical fusion of his lumbar spine from L4 through the sacrum in 1973. After recovering from the surgery, claimant worked for an Oregon plywood manufacturer from 1973 to 1982. From 1982 to January 1984, he worked as a self-employed auto body repairer and mechanic. In January 1984, he returned to the plywood industry as a "busheler" with the employer which is a party to this proceeding. As a busheler, claimant assembled sheets of plywood from pieces of veneer. The job required a considerable amount of rapid and repetitive twisting at the waist. He worked full time from January 1984 through January 1986 with the exception of a two-month layoff during the summer of 1984.

Claimant's off-work activity between January 1984 and January 1986 included occasional auto body repair and mechanical work. In addition, on weekends and evenings between July 1985 and the time of the hearing in October 1986, he assisted contractors and others in the addition of a second story to his home.

In early 1985, claimant began to experience gradually increasing low back pain. By January 1986, this pain had increased to the point where he was no longer able to perform his job as a busheler. He left work on January 21, 1986 and sought medical treatment. Claimant's back pain improved somewhat after he left work, but has never returned to where it was before January 1984.

Diagnostic tests conducted after claimant left work identified degeneration of the facets of the lumbar vertebrae above L4 as the cause of claimant's increased low back pain. The degeneration was the result of three interrelated factors: (1) the immobilization of claimant's lower lumbar vertebrae as a result of the fusion surgery in 1973; (2) claimant's work activity; and (3) claimant's off-work activity. Of the latter two factors, the second contributed more to the degeneration than the third.

ULTIMATE FINDINGS OF FACT

Claimant's underlying degenerative low back condition worsened between January 1984 and January 1986. Claimant's work activity for the employer during that period was the major contributing cause of the worsening, or acceleration, of the degenerative condition.

CONCLUSIONS OF LAW

To establish a compensable occupational disease, claimant has the burden of proving that his work activity for the employer from January 1984 to Janaury 1986 was the major contributing cause of a worsening of his underlying low back condition. Weller v. Union Carbide Corp., 288 Or 27, 35 (1979); see also Dethlefs v. Hyster Co., 295 Or 298, 310 (1983).

There are four medical opinions on the questions of whether claimant's underlying low back condition worsened between January 1984 and January 1986 and whether the worsening was due at least in part to claimant's work activity during that period. Dr. Manley, a consulting orthopedic surgeon, and Dr. Horniman, a consulting general practitioner, opined that claimant's work activity contributed to a worsening of symptoms, but did not worsen his underlying condition. Dr. Franks, a consulting neurosurgeon, and a panel of the Orthopaedic Consultants opined that claimant's underlying condition did worsen and that the worsening was due in part to his work activity.

Franks' and the Consultants' opinions are supported by claimant's testimony to the effect that his back pain gradually increased between January 1984 and January 1986 and never returned to its original level after he left work. We find these opinions and claimant's testimony persuasive and conclude that claimant's underlying low back condition did worsen between January 1984 and January 1986 and that the worsening was due at least in part to his work activity during that period.

This leaves the question of whether claimant's work activity was the major contributing cause of the worsening. No medical opinion answers this question directly. As noted in our findings of fact, however, the record does indicate that there were three factors which contributed to the worsening. Those factors are claimant's fused lower lumbar vertebrae, his work activity and his off-work activity.

The fusion of claimant's lumbar vertebrae from L4 through the sacrum required the vertebrae above L4 to compensate for the loss of mobility resulting from the fusion and thus made them susceptible to degeneration. This "predisposition" or susceptibility cannot be a disease in and of itself. See Preston v. Wonder Bread, 96 Or App 613 (1989); Tucker v. Liberty Mutual Insurance Company, 87 Or App 607 (1987). However, if the major contributing cause of the worsening, or acceleration, of that degeneration was claimant's work activities, his preexisting low back condition is compensable. See Weller, supra; Dethlefs, supra.

Here, claimant's low back condition has progressively worsened since his 1973 fusion surgery. Such a natural degeneration was anticipated by the medical experts. Yet, based on the opinions authored by Franks and the Consultants, we are persuaded that claimant's condition has degenerated at an accelerated rate. Moreover, we find that the major contributing cause of the acceleration of claimant's degenerative condition since he began working for the employer in 1984 were his work activities for the plywood mill. Consequently, we hold that claimant has proven a compensable occupational disease.

ORDER

The Referee's order dated October 17, 1986 is affirmed. Claimant's attorney is awarded $1,000 for services on Board review, to be paid by Liberty Northwest Insurance Corporation.

HOLLY COLBERT, Claimant
Doblie & Associates, Claimant's Attorneys
Schwabe, et al., Defense Attorneys

WCB 87-17879
September 29, 1989
Order on Review

Reviewed by Board Members Gerner and Myers.

The insurer requests review of Referee Podnar's order that set aside its partial denial of claimant's medical services claim for chiropractic treatment of a low back condition. We affirm.

ISSUE

Reasonableness and necessity of chiropractic treatment for a low back condition.

FINDINGS OF FACT

We adopt the first and second paragraphs of the "FINDINGS" portion of the Referee's order with the following supplementation.

Claimant has a congenital malformation in the low back, called a bat-wing transverse process. The malformation consists of a sixth lumbar vertebrae with "wings" that connect to the top of the sacrum on both sides. Claimant's low back pain began only after the compensable lumbosacral strain in August, 1987. Claimant first treated with Dr. Shipp, chiropractor, at a frequency of six times per week. Treatment relieved her low back pain and allowed her to continue working at her regular job. As her symptoms subsided, treatment frequency was reduced. Treatment continued after the denial of chiropractic treatment issued on November 4, 1987, until it was terminated in late January, 1988. At the time of hearing, claimant continued to work at her original job and had no symptoms relating to her compensable back injury. At hearing, claimant admitted to having returned to preinjury status.

FINDING OF ULTIMATE FACT

Chiropractic treatment was reasonable and necessary for the effects of the compensable low back injury.

CONCLUSIONS OF LAW AND OPINION

We are persuaded that further chiropractic treatment was reasonable and necessary in this case. For her 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 services are compensable provided 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). Palliative treatment that reduces claimant's pain and enables her to work is reasonable and necessary. See West v. SAIF, supra, 74 Or App 321. Claimant bears the burden of proving that treatment is reasonable and necessary. James v. Kemper Ins. Co., 81 Or App 80, 81 (1986).

Here, we were most persuaded by claimant's testimony that Dr. Shipp's treatment provided her pain relief and allowed her to continue working at her regular job. The independent medical examiners -- Dr. Howell and Drs. Tilden and Stewart of the Western Medical Consultants -- opined that chiropractic treatment was not reasonable and necessary. They indicated that further chiropractic

treatment would not benefit claimant and, indeed, that cessation of treatment would benefit her. However, those opinions are not persuasive in light of claimant's testimony that her symptoms were relieved by treatment. We find that it was the treatment that improved the condition, which allowed for the curtailment of treatment; not the curtailment of treatment which caused the improvement. The chiropractic treatment was reasonable and necessary. See West v. SAIF, supra.

ORDER

The Referee's order dated March 10, 1988, is affirmed. The Board approves a client-paid fee not to exceed $1070. For services on review, claimant's attorney is awarded a reasonable fee of $750, to be paid by the insurer.

PAULINE J. PETERSON, Claimant
Kirkpatrick & Zeitz, Claimant's Attorneys
Schwabe, et al., Defense Attorneys

WCB 87-15600
September 29, 1989
Order on Review

Reviewed by Board Members Myers and Gerner.

The insurer requests review of Referee McGeorge's order that: (1) set aside its denial of claimant's medical services claim for treatment of neck and upper back symptoms; (2) set aside its denial of claimant's aggravation claim for the same symptoms; and (3) awarded claimant's attorney an assessed fee for prevailing against those denials. We reverse.

ISSUES

1. Compensability of medical treatment for neck and upper back symptoms.

2. Compensability of aggravation claim for same symptoms.

3. Claimant's entitlement to an assessed fee for prevailing against the insurer's denials.

FINDINGS OF FACT

We adopt the "FINDINGS OF FACT" portion of the Referee's order with the following supplementation.

After the compensable low back injury, claimant returned to unrestricted work in July, 1987. Her back felt "pretty good" at work. Her employment was terminated on July 29, 1987. On the morning of September 1, 1987, four months after the compensable injury, claimant first noticed increasing discomfort in the neck and upper back while reading a newspaper. She sought medical treatment for those symptoms the following day.

FINDING OF ULTIMATE FACT

Claimant's compensable low back injury did not materially contribute to her current neck and upper back symptoms.

CONCLUSIONS OF LAW AND OPINION

We adopt the first paragraph of the "OPINION" portion of the Referee's order with the following supplementation.

In order to prevail on either the claim for aggravation or for medical services, claimant must prove that her original low back injury materially contributed to her current neck and upper back symptoms. See Grable v. Weyerhaeuser Company, 291 Or 387, 400-01 (1981); Van Blokland v. Oregon Health Sciences University, 87 Or App 694, 698 (1987). The only medical opinion supporting compensability is offered by Dr. Biska, the treating physician since May, 1987. Biska diagnosed claimant's neck and upper back symptoms as acute severe myalgia and neuralgia involving the dorsal and cervical musculature, and he related them to the compensable injury of April, 1987. He explained: "Especially upon comparing [claimant's] past history of low back injury and subsequent upper back and neck pain problems with her more recent injury [of April, 1987], one is convinced there is an undeniable relationship in both the history and the anatomy." Contrary opinions were offered by Drs. Graham and Horniman. Both opined that the current complaints were of a "spontaneous" origin.

The Referee found treating physician Biska's opinion most persuasive. We disagree. Although we ordinarily give the treating physician's opinion greater weight, see Weiland v. SAIF, 64 Or App 810, 814 (1983), we decline to do so where, as here, the opinion is conclusory and speculative. The primary basis for Biska's opinion is the comparison between the compensable injury of April, 1987, and claimant's "past history of low back injury and subsequent upper back and neck problems." Yet, Biska fails to discuss the "past history" in any significant detail. Presumably, he is referring to claimant's prior compensable injury of April, 1985, which was initially diagnosed as a low back strain but later resulted in neck and shoulder pain. Notwithstanding claimant's prior medical history, it is clear that Biska bases his opinion on chronological sequence. We decline to infer causation from mere chronological sequence. See Bradshaw v. SAIF, 69 Or App 587, 589-90 (1984); Edwards v. SAIF, 30 Or App 21, 24, rev den 279 Or 301 (1977). In so declining, we consider the following circumstances. First, current symptoms are located in the neck and upper back, whereas the compensable injury occurred in the low back. Second, there was a four-month lapse between the compensable low back injury and the onset of neck and upper back symptoms. Third, claimant has cervical degenerative disc disease which preexisted and was not worsened by the compensable injury.

Those circumstances led Drs. Graham and Horniman to attribute claimant's current symptoms to "spontaneous" exacerbation of degenerative disc disease, unrelated to the compensable injury. After reviewing the record, we are most persuaded by their better-reasoned opinions. See Somers v. SAIF, 77 Or App 259, 263 (1986). Claimant's medical services and aggravation claims are not compensable. Because we uphold the denials, the Referee's assessed fee award is disallowed. See ORS 656.386(1).

ORDER

The Referee's order dated March 16, 1988, is reversed. The insurer's denials of October 5, 1987, and November 17, 1987, are reinstated and upheld. The Referee's assessed fee award of $1,500 is disallowed. The Board approves a client-paid fee not to exceed $1,384.

CLIFFORD J. WADKINS, Claimant
Malagon, Moore & Johnson, Claimant's Attorneys
Brian L. Pocock, Defense Attorney

WCB 87-17357
September 29, 1989
Order on Review

Reviewed by Board Members Myers and Gerner.

Claimant requests review of those portions of Referee Duncan's order that: (1) upheld the self-insured employer's partial denial of claimant's medical services claim for treatment of a cervical condition; and (2) declined to assess a penalty and attorney fee for the employer's allegedly unreasonable denial of the same.

ISSUES

1. Compensability of treatment for claimant's cervical condition.

2. Penalty and attorney fee for the employer's allegedly unreasonable denial of the same.

We reverse on the compensability issue and affirm the remainder of the Referee's order.

FINDINGS OF FACT

We adopt the "FINDINGS OF FACT" portion of the Referee's order.

FINDINGS OF ULTIMATE FACT

Claimant's use of the crutches was a direct and natural consequence of his compensable knee injuries, and materially contributed to his cervical condition and resulting need for treatment. However, the employer had legitimate doubt of its liability for cervical treatment.

CONCLUSIONS OF LAW AND OPINION

The Referee upheld the partial denial, reasoning that claimant had not sustained his burden of proving a compensable relationship between the use of crutches and the need for treatment of his cervical condition. We disagree.

To establish the compensability of medical treatment for a condition, claimant must prove by a preponderance of the evidence that the compensable injury was a material contributing cause of his need for that treatment. ORS 656.245(1); Van Blokland v. Oregon Health Sciences University, 87 Or App 694, 698 (1987). Injuries sustained during activities which are a "direct and natural consequence" of the original industrial injury are injuries arising out of and in the course of employment, and are therefore compensable. Wood v. SAIF, 30 Or App 1103, 1109-10 (1977), rev den 282 Or 189 (1978). For example, if the use of crutches for the continuing effects of an industrial knee injury is a direct and natural consequence of that injury, any subsequent injury resulting from the use of those crutches is also compensable. See Eber v. Royal Globe Insurance Co., 54 Or App 940, 943 (1981). Here, it is undisputed that claimant's use of the crutches is a direct and natural consequence of the original industrial knee injuries.

Claimant seeks to prove that his current cervical condition and related need for treatment were materially related to the use of crutches that were required for the effects of his original industrial knee injuries. He testified that, in April, 1987, he felt an immediate onset of sharp pain in the neck and throughout the left arm after stumbling and nearly falling onto the crutches. He saw Dr. Fox, his family physician, who diagnosed a cervical strain. A subsequent myelogram and CT scan revealed a small left C5-6 disc herniation with compression upon the left C6 nerve root. Dr. Golden, a neurosurgeon, performed a cervical laminectomy in July, 1987, and removed a large arthritic spur that was compressing the nerve root. Claimant's condition significantly improved after surgery.

Drs. Fox and Golden, the treating physicians, both relate the cervical condition and need for treatment to claimant's use of the crutches. Golden diagnosed chronic cervical strain and cervical spondylosis and opined that the neck injury was caused "when [claimant] fell down," presumably referring to the near-fall onto crutches in April, 1987. Fox testified in his deposition that, while the use of crutches did not cause the arthritic spur that was surgically removed, it did exacerbate claimant's symptoms and result in the need for treatment. On the other hand, Dr. Howell, the osteopath who performed an independent medical examination, related claimant's symptoms and need for treatment to the natural progression of preexisting cervical degenerative disc disease, rather than the crutch incident.

The Referee found the above evidence insufficient to establish a causal relationship between the crutch incident and the herniated disc. However, that is not the dispositive inquiry. Rather, the dispositive inquiry is whether the crutch incident materially contributed to claimant's need for treatment, i.e., the onset or increase of symptoms of a preexisting, noncompensable disease. If so, that treatment is compensable. See Grace v. SAIF, 76 Or App 511, 517 (1985); von Kohlbeck v. SAIF, 68 Or App 272 (1984). We are persuaded by claimant's testimony regarding the immediate onset of severe neck and arm pain after the crutch incident. Although claimant had a prior medical history of cervical strains and degenerative disc disease dating back to 1976, his cervical spine was asymptomatic immediately prior to the crutch incident. Yet, immediately after that incident, he felt sharp neck and left arm pains unlike anything he had ever felt before. Given claimant's persuasive testimony, we conclude that the opinions of Drs. Fox and Golden regarding causation are better-reasoned than that of Dr. Howell. See Somers v. SAIF, 77 Or App 259, 263 (1986). Based on the forgoing evidence, we find that the crutch incident and resulting cervical strain materially contributed to the onset of cervical symptoms resulting in the need for treatment. Hence, that treatment is compensable. See Grace v. SAIF, supra; von Kohlbeck v. SAIF, supra.

However, claimant is not entitled to any penalty and attorney fee for the denial. The employer had Howell's report indicating that the cervical condition and need for treatment was related to the natural progression of preexisting degenerative disc disease, rather than the crutch incident. That report supplied the employer a legitimate basis for denying liability for

cervical treatment. Its denial was not unreasonable. See Peterson v. SAIF, 78 Or App 167, 172, rev den 301 Or 193 (1986).

ORDER

The Referee's order dated April 5, 1988, is reversed in part and affirmed in part. That portion of the order that upheld the self-insured employer's partial denial of claimant's medical services claim for treatment of a cervical condition is reversed. That claim is remanded to the employer for processing according to law. The remainder of the Referee's order is affirmed. Claimant's attorney is awarded a reasonable assessed fee of $2,000 for services at hearing and on review concerning the medical services issue, to be paid by the employer.

MARIO T. ZEMAN, Claimant
E. Jay Perry, Defense Attorney

WCB 87-08836
September 29, 1989
Order on Review

Reviewed by Board Members Gerner and Myers.

Claimant, pro se, requests review of Referee Mills' order that upheld the insurer's denial of his injury claim.

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

ISSUES

1. Whether claimant's industrial injury claim should be barred as untimely.

2. Whether claimant sustained a compensable injury to his back on November 28, 1986.

FINDINGS OF FACT

Save for the last two paragraphs of the Referee's Findings of Fact, the Board adopts his findings. In lieu of those two paragraphs, the Board finds as follows:

Claimant had to open the gate to the premises in order to get a trailer to hook up to the crummy.

Due to the seasonal nature of claimant's work, he did not work from December, 1986, through March, 1987. He sought no medical treatment during that period. On April 8, 1987, he filed an industrial injury claim for a strain to the left side of his body, allegedly sustained on November 28, 1986. The employer was without notice or knowledge of any such injury, until claimant filed his claim on April 8, 1987.

On April 9, 1987, claimant consulted Dr. Boothby, a chiropractor. Boothby diagnosed, inter alia, cervical myofascitis and took claimant off work.

CONCLUSIONS OF LAW

Timeliness

The Board adopts that portion of the Referee's opinion concerning whether claimant's claim was time barred.

Compensability

Given the Referee's finding of untimeliness, he declined to reach the merits of whether claimant had proven a compensable injury. On review, we proceed to do so. See Grimes v. SAIF, 87 Or App 597, on rem 40 Van Natta 1223 (1988).

Based on his observation of appearance and demeanor, the Referee found that claimant "lacked credibility." We agree. Coastal Farm Supply v. Hultberg, 84 Or App 282 (1987). Claimant testified that on the morning of November 28, 1986, he hurt his back while attempting to open a gate. He felt excruciating back pain and leaned against the gate for about two minutes. Immediately thereafter, he informed co-workers Shenkin and Fuller of his injury. Shenkin and Fuller finished opening and closing the gate. Later that day, he informed Mr. Viscardi, a corporate officer for the employer, about his injury. The following week, he spoke further with Viscardi and also informed Mr. Wilson, a manager for the employer, of his injury.

The Referee found all the other witnesses credible. Again, we agree. Hultberg, supra. Co-worker Shenkin recalled only that claimant mentioned that he had hurt his back, during a morning sometime in November, 1986. Shenkin "believe[d]" that he was inside the truck, when claimant informed him of his back pain. He thought it was "possible," however, that claimant had not finished opening the gate and that he, Shenkin, completed the opening and closing of the gate.

Co-worker Fuller did not recall any incident or injury to claimant on November 28, 1986. In addition, he did not recall that claimant mentioned hurting his back or that he was unable to finish opening and closing of the gate. On cross-examination, however, Fuller conceded that he could not confirm or deny what happened on that day, because he did not recall the events of November 28, 1986.

Mr. Viscardi denied that claimant informed him of an injury sustained on November 28, 1986. Viscardi testified that he was not aware of any such injury, until claimant filed his claim on April 8, 1987.

Mr. Wilson denied that claimant spoke with him about any injury on or about November 28, 1986, or within approximately one week thereafter.

After our de novo review, we are not persuaded that claimant hurt or injured his back on the morning of November 28, 1986. First, claimant is not credible. Second, Mr. Viscardi and Mr. Wilson flatly contradict claimant's testimony that he informed them of his injury within one week of November 28, 1986. Third, co-worker Fuller has no recollection of the day in question and does not help claimant prove his case. Fourth, co-worker Shenkin only recalled that claimant mentioned hurting his back after closing the gate during some morning in November, 1986. He could only speculate as to whether claimant had, in fact, not completed opening the gate or whether he, Shenkin, finished the opening and closing of the gate. Fifth, despite his alleged injury, claimant completed his work shift on November 28, 1986. Last, claimant did not seek any medical treatment until April 9, 1987; i.e, nearly five months after his alleged injury.

Further, due to the lengthy delay from the alleged injury to the date of first medical treatment, there is a question as to the

medical relationship between the injury and the need for treatment. See Uris v. Compensation Department, 247 Or 420 (1967). The medical opinion rendered by claimant's treating physician only indicates that the relationship between the alleged injur and the need for treatment was "plausible" and that the accident "could have" caused the treatment. Claimant is required to prove a relationship between the work incident and the need for medical treatment to a reasonable medical probability. A statement of a physician of mere possibility or speculation does not meet that requirement. Gormely v. SAIF, 52 Or App 1055 (1981). Claimant has failed to prove, to a reasonable medical probability, a material relationship between the alleged accident and the ensuing need for treatment.

ORDER

The Referee's order, dated February 16, 1988, is affirmed. The Board approves a client-paid fee, payable from the Liberty Northwest Insurance Corporation to its attorney, not to exceed $585.50.

ORDERS OF ABATEMENT

MICHAEL D. BRUNER, Claimant
Welch, et al., Claimant's Attorneys
Beers, et al., Defense Attorneys

Own Motion 88-0065M
September 7, 1989
Own Motion Order of Abatement

The insurer requests immediate abatement and reconsideration of our Own Motion Order on Reconsideration dated August 23, 1989, that set aside as premature the insurer's November 9, 1988 Notice of Closure. Submitting several reports, letters, and an affidavit from its claims examiner, the insurer disagrees with our conclusion that the claim was prematurely closed.

In order to fully consider the matter, we abate and withdraw our August 23, 1989 order. Claimant is granted an opportunity to respond to the insurer's motion. To be considered, claimant's response should be submitted within 14 days from the date of this order. Thereafter, this matter shall be taken under advisement.

IT IS SO ORDERED.

RACHID KAADY, Claimant
Paul Rask, Claimant's Attorney
Pozzi, et al., Attorneys
Schwabe, et al., Attorneys
Cooney, Moscato & Crew, Attorneys
Michael Kohlkoff, Attorney
Acker, Underwood, et al., Attorneys

WCB TP-89004
September 14, 1989
Order of Abatement

The Board has received EBI's motion for reconsideration of our Third Party Distribution Order dated August 17, 1989.

In order to allow sufficient time to consider the motion, the above noted Board order is abated and withdrawn. The Professional Liability Fund, on behalf of claimant, is requested to file a response to the motion within ten days. Thereafter, this matter shall be taken under advisement.

IT IS SO ORDERED.

KATHERINE A. RELPH, Claimant
Coons & Cole, Claimant's Attorneys
Roberts, et al., Defense Attorneys

WCB 84-03505
September 13, 1989
Order of Abatement

The insurer has requested reconsideration of that portion of our August 14, 1989, Order on Reconsideration that adhered to and republished that portion of our June 30, 1989, Order on Review, which concluded that the Referee correctly declined to authorize an offset of allegedly overpaid temporary disability benefits for the period December 5, 1984, to July 15, 1985.

In order to allow sufficient time to consider the motion, our prior orders are abated and withdrawn. Claimant is requested to file a response to the motion within ten days from the date of this order. Thereafter, we shall take the insurer's motion under advisement.

IT IS SO ORDERED.

RAYMOND E. TISDALE, Claimant
EBI Companies, Insurance Carrier

Own Motion 89-0417M
September 1, 1989
Own Motion Order of Abatement

Claimant requests that the Board reconsider its August 11, 1989, Own Motion Order which denied his request for claim reopening based on the finding that he had retired from the work force. Claimant specifically requests that the aforementioned order be abated pending his submission of additional evidence to the Board.

In order to allow sufficient time to consider claimant's motion, the above-noted Board order is abated and withdrawn. Claimant has fifteen days within which to submit additional evidence. The insurer shall then have ten days within which to submit a response. Thereafter, this matter shall be taken under advisement.

IT IS SO ORDERED.

WORKERS' COMPENSATION CASES

Decided in the Oregon Supreme Court:

Decided in the Oregon Court of Appeals:

IN THE COURT OF APPEALS OF THE STATE OF OREGON

LEDESMA,
Appellant,
v.
FREIGHTLINER CORPORATION,
Respondent.

(A8602-01084; CA A48225)

Appeal from Circuit Court, Multnomah County.

Robert W. Redding, Judge.

Argued and submitted March 6, 1989.

Peter W. McSwain, Portland, filed the brief for appellant.

Janet M. Schroer, Portland, argued the cause for respondent. On the brief were M. Elizabeth Duncan, Ridgway K. Foley, Jr., and Schwabe, Williamson & Wyatt, Portland.

Before Buttler, Presiding Judge, and Warren and Rossman, Judges.

ROSSMAN, J.

Affirmed.

ROSSMAN, J.

Plaintiff brought this action pursuant to ORS 659.410,[1] alleging that he was wrongfully discharged because he filed a workers' compensation claim. The trial court found for defendant on stipulated facts. We affirm.

Plaintiff worked as a painter for defendant from October 18, 1983, until he was fired on July 11, 1985. He injured his back at work on February 5, 1985, and filed a workers' compensation claim shortly thereafter. Between the time of his injury and the time of his discharge, plaintiff received workers' compensation benefits. During that time, he was on a medical leave of absence, allowing him to do full-time work with light duties or part-time work with light duties or be on layoff status, as medical requirements might dictate. The medical limitations prescribed by his physician included lifting and carrying objects weighing 11-20 pounds only occasionally and those weighing up to five pounds continuously, with no pulling, no bending, no squatting, no crawling and no climbing. In May or June, defendant received information that plaintiff was doing work on his own time that was inconsistent with those limitations—operating a chain saw, chopping and stacking wood, repairing and painting automobiles and driving a go-cart that could attain speeds of up to 60 mph. Defendant also received two surveillance reports. The first

[1] ORS 659.410 provides:

"It is an unlawful employment practice for an employer to discriminate against a worker with respect to hire or tenure or any term or condition of employment because the worker has applied for benefits or invoked or utilized the procedures provided for in ORS 656.001 to 656.794 and 656.802 to 656.807 or of 659.400 to 659.435 or has given testimony under the provisions of such sections."

report stated that plaintiff was doing various tasks outside his house with "no actions that indicated pain or impairment other than a slight limp * * *." However, when plaintiff noticed that he was being watched from a parked car across the street, he went inside and came out wearing a back harness. He walked slowly with a pronounced limp, over to the observer's car and asked him to leave. The observer also reported that he saw plaintiff lift an eight-foot florescent shop light, weighing about 40 to 50 pounds, without any indication of pain. The other report stated that, on July 11, when plaintiff arrived for his scheduled doctor's appointment and got out

of the car, his "posture was relatively upright, his movements were fluid, and the only possible problem noted was a slight limp." However, as plaintiff approached the doctor's office, he adjusted his back brace and began walking with "a very pronounced limp and with a much poorer posture * * * with his shoulders and head shrugged forward." After receiving that information, defendant discharged plaintiff for misrepresenting his physical condition and his ability to work.

Plaintiff filed a complaint pursuant to a collective bargaining agreement. Under the grievance procedure provided for in that agreement, a joint panel of two union and two management members found that plaintiff was discharged for cause. He then filed a charge with the Bureau of Labor and Industries (Bureau), claiming that he was discharged because of his injured worker status, in violation of ORS 659.410. Bureau found no substantial evidence of an unlawful employment practice. Plaintiff stopped receiving benefits after a workers' compensation hearing in which it was also found that he was fired for cause. Plaintiff appealed that decision, but before it could be reviewed, the parties agreed to a settlement. He then brought this action.

Plaintiff contends that the trial court erred as a matter of law when it failed to find that plaintiff's discharge "due to" his workers' compensation disability status was not a violation of ORS 659.410. He argues that the trial judge misapplied and ignored facts that establish a violation of ORS 659.410, narrowed the scope of that statute by focusing on termination for filing of a workers' compensation claim and failed to allocate the burden of proof properly.[2] We conclude that plaintiff's first two arguments are without merit and that any error committed by the trial judge in shifting the burden of proof actually inured to plaintiff's benefit and was harmless.

The facts show that plaintiff worked for defendant

and that he was fired after he had applied for workers' compensation benefits. Apparently, according to plaintiff, all he need show to recover under ORS 659.410 is that he filed a workers' compensation claim and that he was discharged sometime thereafter. That is not the law.

[2] With regard to the burden of proof, the trial judge said:

"There was [a] filing of a Worker's [sic] Compensation claim [followed] by a discharge * * *[.] [The] reason given for the discharge is misrepresentation of medical condition in regard to filing the claim[.] [T]hat shifts the burden onto the defendant to prove by clear and convincing evidence under close scrutiny that that, in fact, was the reason for the discharge, and that the reason was not simply the filing of the claim."

In Oregon discrimination actions in which the issue is, as it is here, simply whether the plaintiff's allegation or the employer's denial of discrimination is correct, the burden of proof does not shift from the plaintiff after he has put on his *prima facie* case. *Callan v. Confederation of Oregon School Administrators,* 79 Or App 73, 77, 717 P2d 1252 (1986); *see City of Portland v. Bureau of Labor and Industries,* 298 Or 104, 114-15, 690 P2d 475 (1984). After the plaintiff has established his *prima facie* case,[3] the defendant may attempt to show, among other things, a non-discriminatory reason for the termination. If the defendant does so, then the plaintiff may rebut the defendant's case. Here, defendant produced evidence that it fired plaintiff because it discovered that he was lying about his physical limitations and his ability to return to work. The factfinder could believe defendant—and we do.

Plaintiff's filing of a workers' compensation claim was not the reason for his termination. Defendant fired plaintiff because he had lied about his disability status and the extent of his ability to work, not because he filed a workers' compensation claim. Filing the claim merely precipitated a situation that allowed plaintiff to manifest his dishonesty.

Affirmed.

[3] The parties agree that plaintiff satisfied his *prima facie* burden.

IN THE COURT OF APPEALS OF THE STATE OF OREGON

STEINER,
Respondent,
v.
BEAVER STATE SCAFFOLDING EQUIPMENT CO.,
Appellant,
v.
BOUWMAN TUBULAR SCAFFOLD COMPANY, INC.,
Third-Party Defendant.

(A8603-01295; CA A48107)

Appeal from Multnomah County Circuit Court.

Charles S. Crookham, Judge.

Argued and submitted February 27, 1989.

Don G. Carter, Portland, argued the cause for appellant. With him on the briefs were Janice M. Stewart, Karen D. Randolph and McEwen, Gisvold, Rankin & Stewart, Portland.

Robert K. Udziela, Portland, argued the cause for respondent. On the brief were Raymond J. Conboy, Jeffrey S. Mutnick and Pozzi, Wilson, Atchison, O'Leary & Conboy, Portland.

Before Graber, Presiding Judge, and Joseph, Chief Judge, and Edmonds, Judge.

JOSEPH, C. J.

Reversed and remanded with instructions to dismiss Employers' Liability Act claim and to enter judgment for plaintiff in accordance with jury's verdict on negligence claim.

JOSEPH, C. J.

Plaintiff's employer, E.J. Bartells Co., was hired to insulate and weatherize a large tank. Bartells contracted with Beaver State Scaffolding Equipment Co. (defendant) to erect a scaffold at the job site. Defendant installed the scaffold before the insulation work began and had no further involvement with the project until after Bartells had completed its work, when defendant's personnel returned to the site to dismantle the scaffold. Plaintiff was injured when he fell from the scaffold while performing the insulation work for Bartells. He brought this action against defendant, alleging negligence and a violation of the Employer's Liability Act (ELA). ORS 654.305 *et seq.* The jury found for plaintiff on both claims but found him contributorily negligent and fixed his comparative fault at 49 percent on the negligence claim and 35 percent on the ELA claim. Therefore, the judgment reflected plaintiff's choice to have the damage award calculated in accordance with the verdict on the ELA claim. Defendant appeals from the resulting judgment.[1]

Defendant first contends that it was not on the job site while plaintiff was working and that it had no involvement in his job activity and no control over the scaffold when he was using it. Therefore, according to defendant, it cannot be liable under ELA and the trial court erred by denying defendant's motion for a directed verdict on ELA claim.[2] The general issue raised by defendant's argument is when and whether ELA applies to a person, other than the injured worker's actual employer, who brings the injury-causing goods or equipment to the workplace. The specific question is whether a maker or supplier of unsafe equipment can be liable under ELA if it has no involvement with the work or control of the equipment or its use after installing and delivering it.

The leading Oregon case is *Thomas v. Foglio*, 225 Or 540, 358 P2d 1066 (1961). The plaintiff was injured while loading logs for his actual employer on a truck that the defendant owned and had brought onto the employer's premises. The court held that the defendant could be the plaintiff's "indirect employer" and liable to him under ELA. It first explained:

[1] We will state additional facts in our discussion of the issues to which they are relevant.

Defendant brought a third party action against Bouwman Tubular Scaffold Company, Inc., from which it had purchased the scaffolding. Defendant obtained a judgment against Bouwman that is not involved in this appeal.

[2] Defendant also argues, for the same reasons, that the court erred by denying its motion for partial summary judgment. Because the rulings on the two motions turn on the same issues, we need not discuss the denial of the summary judgment separately or decide whether it is reviewable. *See Payless Drug Stores v. Brown*, 300 Or 243, 708 P2d 1143 (1985); *Stromme v. Nasburg and Co.*, 80 Or App 26, 721 P2d 847, *rev den* 302 Or 35 (1986).

"It would seem clear that one who merely sells equipment which is intended for use and is used by workmen and who, after the sale, is not involved in the use to which the equipment is put, is not an employer under [ELA]. * * * At this point we simply wish to note that one who merely supplies equipment which is to be used in the course of plaintiff's employment is not an employer under the Employers' Liability Law [*sic*]. This is also true where the equipment is leased rather than sold. [ELA] cannot apply unless in some sense the defendant has 'charge of' or is 'responsible for' the work out of which the injury arose." 225 Or at 545.

The court then said, however:

"The narrower question presented to us in the case at bar (assuming that defendant was not a lessor of the trucks[)] is whether an employer can be regarded as 'having charge of' work where the component part of the general undertaking for which he is responsible does not involve any risk-creating *activity* on the part of his employee but does call for the use of equipment over which he has control and which, if not maintained with proper safeguards, necessarily exposes the employees of the other employer to an unreasonable risk in the course of carrying on the common enterprise. In a narrow sense, it could be said that in such a case the defendant employer does not have charge of work but has charge only of equipment. But the word 'work' in ORS 654.305 means more than the actual physical movement of the employees hired to perform a job; it means the entire enterprise with all of the component parts necessary to the completion of the enterprise in which both employers have joined to accomplish. Thus in the instant case the defendant had 'charge of' and was 'responsible for' that part of the job or 'work' which consisted of furnishing safe equipment to be used in a loading operation." 225 Or at 549. (Emphasis in original.)

The court then reiterated its first point:

"What we have said here does not mean that a manufacturer, vendor, or a similar supplier, including a lessor of equipment[,] is within [ELA]. The defendant must participate in the activity out of which the injury arose." 225 Or at 550.

As we indicated in *Dingell v. Downing-Gilbert, Inc.*, 81 Or App 545, 550, 726 P2d 937 (1986), *rev den* 302 Or 614 (1987), *Thomas v. Foglio, supra,* draws a less than bright line between manufacturers and suppliers who are subject to ELA liability and those who are not. Some language in the opinion clearly suggests that the mere introduction of unsafe equipment to the work site is not enough to permit ELA to be invoked against the manufacturer or supplier; other language suggests that bringing equipment to the site, *per se,* vests the supplier with ELA responsibility for its safety.

The quoted language from *Thomas v. Foglio, supra,* does not expressly resolve whether the applicability of ELA depends—at a minimum—on the provider having *continuing* control over the equipment after introducing it to the workplace. However, *Thomas* does suggest that the answer is yes, by saying that the defendant's ELA responsibility arose from the employes' "use of equipment over which [the defendant] has control and which, if not maintained with proper safe-

guard, necessarily exposes the employees of the other employer to an unreasonable risk." *See also Sacher v. Bohemia, Inc.*, 302 Or 477, 486, 731 P2d 434 (1987).

It would make little sense for ELA to be applicable to a manufacturer or provider who does not retain any control over the equipment or its use. Although the word "employer" hardly carries its traditional and usual connotation in the ELA context, the overriding purpose of the statute is to require that actual employers assure job safety. *See Wilson v. P.G.E. Company,* 252 Or 385, 448 P2d 562 (1968). Although ELA also applies to those whom the courts have denominated "indirect employers," it has no logical application and has not been judicially applied to persons who have no nexus with either the employes' work activity or their work-related use of goods or equipment. The law of negligence and strict products liability, rather than ELA, provides the appropriate recourse against manufacturers and suppliers who furnish unsafe equipment but retain no control over or connection with it or its use. *See Parks v. Edward Hines Lbr. Co. et al,* 231 Or 334,

339, 372 P2d 978 (1962); *Dingell v. Downing-Gilbert, Inc., supra,* 81 Or App at 551-52.

Plaintiff argues that, even given a requirement of ongoing control, there was evidence here that defendant retained enough control over the scaffold to be subject to ELA. Plaintiff points to testimony that defendant would have been responsible for modifications, maintenance or repairs of the scaffold, if any had been necessary during the course of the insulation work. That evidence has no tendency to show that defendant in fact had control. Defendant was never at the job site during the course of the insulation work and was not expected or required to be there. Any duty that it might have had to perform maintenance or repairs could have only arisen at plaintiff's employer's request and could not amount to the kind of ongoing control of or responsibility for the equipment necessary to give rise to ELA liability. The trial court erred by denying defendant's motion for a directed verdict on the ELA claim.

Four of defendant's assignments of error pertain to the negligence claim.[3] The scaffold had a built-in access frame, which could be used for climbing, instead of a separate ladder. Plaintiff alleged, *inter alia,* that defendant negligently constructed the frame with rungs separated by unequal distances and that defendant thereby violated applicable federal and state safety regulations. At trial, plaintiff argued that the regulatory requirement that ladders have a uniform 12-inch distance between rungs applies to scaffold access frames as well as ladders. *See* OAR 437-88-110(2); 29 CFR 1910.27(b)(ii). After the jury had heard that theory, the trial

[3] In another assignment, defendant contends that the court erred by submitting a special verdict form to the jury that called upon it to make separate comparative fault determinations with respect to the two claims. We do not understand that assignment to relate to the negligence claim. If it is so intended, however, it cannot have caused prejudice, because the jury found the comparative fault under the negligence claim to be greater than the comparative fault under the ELA claim. Defendant does not take issue with the comparative fault instructions on either claim; it challenges only the verdict form that allowed the jury to make two findings on what defendant regards as one question.

court rejected it as a matter of law. However, the court concluded that OAR 437-83-1997 and 29 CFR § 1926.251(a)(13) are applicable and that they required that the scaffold have an "access ladder or equivalent safe access."

Defendant does not disagree. It argues, however, that the court erred by reading a dictionary definition of "ladder" to the jury after instructing it on the "equivalent safe access" regulations and noting that they contain no definition. The point of defendant's argument is that the reading of the definition could have reinforced the erroneous link between the scaffold and the ladder regulations that plaintiff's arguments created in the jurors' minds. Defendant disregards the fact that what the "equivalent safe access" standard requires is a finding of equivalency with a ladder. The meaning of "ladder" is as material to the application of the "equivalent safe access" requirement as to the application of the ladder regulations themselves. The reading of the definition was not erroneous for any reason that defendant advances.

Defendant next assigns error to the court's refusal to give this requested instruction:

> "You are instructed that the scaffold erected by defendant was not required by law to have a uniform twelve inch distance between the rungs."

Plaintiff responds that the instruction would have been an improper comment on the evidence, because the proof permitted a finding that the frame could not be equivalently safe unless its rungs comported with those of a complying ladder. We agree that the requested instruction was properly refused. Although it is not a comment on the evidence, it could have confused the jury by indicating that defendant was not required "by law" to do the very thing which the jury was to decide whether defendant was negligent for not doing. Moreover, defendant was not entitled to an instruction that it was not negligent *per se*, when there was no issue of negligence *per se*.

Defendant's next assignment is that the court erred by excluding parts of plaintiff's supervisor's accident report that defendant sought to have admitted. We agree with plaintiff that the foundation for the evidence was inadequate, because the source of the information and the knowledge of the persons from whom it might have come were not sufficiently established. OEC 803(6).

Defendant's last assignment is concerned with statements in plaintiff's arguments to the jury that defendant's

third party complaint contained admissions of negligence (and of ELA liability). *See* n 1, *supra*. Although not stated, defendant's apparent point is that the argument invited the jury to draw an impermissible inference. After plaintiff's opening statement, defendant moved to exclude the third

party pleading from evidence[4] and to have a curative instruction read to the jury. The court responded:

> "I think I have to hear all of the evidence before I can make such a ruling."

Defendant later objected to plaintiff's attorney's repetition of the judicial admission theme in his closing argument. The objection was overruled.

Assuming both that those rulings were erroneous and that they *could* provide an occasion for appellate relief,[5] we conclude that any error was harmless. The direct evidence of negligence was abundant and convincing, and we regard it as most unlikely that the jury resorted to the third party complaint or to the purported judicial admission in making its findings on plaintiff's negligence claim. Moreover, the jury saw and heard defendant's evidence and arguments. It was fully aware that defendant did not concede liability, and that fact could not have been obscured by plaintiff's makeweight argument.[6]

The trial court committed no reversible error in connection with the negligence claim. The jury's findings on that claim, independently of the ELA claim, support a judgment for plaintiff. Because plaintiff's comparative fault under the negligence claim was greater than the percentage reflected in the judgment, which was based on the ELA claim verdict, we remand for the trial court to recompute damages and to enter a new judgment.

Reversed and remanded with instructions to dismiss Employers' Liability Act claim and to enter judgment for plaintiff in accordance with jury's verdict on negligence claim.

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[4] The third party claim and plaintiff's claims were tried to the same jury.

[5] As far as its assignment and its supporting argument disclose, defendant did not move for a mistrial or object to the admission of the third party complaint when and if it was offered. Defendant's counsel made an abstract request for a curative instruction in her colloquy with the court after the opening argument. However, if defendant submitted a written requested instruction, it is not reproduced or mentioned in its brief. Of the rulings set out in defendant's assignment or mentioned in its argument, only the overruling of the objection to the closing argument is even reviewable.

[6] If the jury gave any consideration to the third party complaint, it probably determined that the pleading did not contain any admissions.

IN THE COURT OF APPEALS OF THE
STATE OF OREGON

In the Matter of the Compensation of
D. E. Rodriguez, Claimant.
LIBERTY NORTHWEST INSURANCE
CORPORATION et al,
Petitioners,
v.
RODRIGUEZ,
Respondent.
(WCB 86-16114; CA A50160)

Judicial Review from Workers' Compensation Board.

Argued and submitted May 24, 1989.

David O. Wilson, Eugene, argued the cause for petitioners. With him on the brief was E. Jay Perry, Eugene.

Marilyn K. Odell, Eugene, argued the cause and filed the brief for respondent.

Before Graber, Presiding Judge, and Riggs and Edmonds, Judges.

RIGGS, J.

Affirmed.

RIGGS, J.

Employer seeks review of a Board order affirming the referee's order, which concluded that claimant's injuries were incurred in the course of employment and therefore are compensable. We review for errors of law and substantial evidence and affirm. *Armstrong v. Asten-Hill Co.*, 90 Or App 200, 752 P2d 312 (1988).

The referee found that claimant was injured when he slipped and fell in employer's parking lot while leaving the premises after having been fired. Claimant was following his normal route from the premises to his bus stop. He fell when he attempted to sidestep a puddle on his path. The parking lot was adjacent to employer's building, and employer was responsible for maintaining it.

The referee concluded that, because claimant was in the process of leaving employer's premises at the direction of employer when he was injured, he was still under the direction and control of employer. The referee also determined that, because claimant slipped and fell while leaving work in a parking lot which employer had a duty to maintain, the claim is compensable under *Montgomery Ward v. Malinen*, 71 Or App 457, 692 P2d 694 (1984). The Board added a finding that claimant had gathered his belongings and left the building immediately after his termination. It affirmed the referee, relying on 1A Larson, *Workmen's Compensation Law* 5-285 § 26.10., which states:

"Injuries incurred by an employee while leaving the premises * * * within a reasonable time after termination of the employment are within the course of employment * * *."

Employer argues that the Board's adoption of the quoted rule conflicts with the "course of employment" test articulated in *Rogers v. SAIF,* 289 Or 633, 616 P2d 485 (1980). The *Rogers* test is whether there is a sufficient relationship between the injury and the employment so that the injury should be compensated. *Rogers v. SAIF, supra,* 289 Or at 642. We see no conflict between the two approaches under the facts here. The Board found that claimant left immediately after his discharge. The Board also found that claimant was under employer's direction to leave the premises and was leaving them when the injuries occurred. Those are significant factors

in finding compensability under the *Rogers* analysis. *See, e.g., Halfman v. SAIF,* 49 Or App 23, 28, 618 P2d 1294 (1980). Employer has abandoned its contention that the Board's findings were not supported by substantial evidence.

Affirmed.

IN THE COURT OF APPEALS OF THE STATE OF OREGON

ACCIDENT PREVENTION DIVISION,
Petitioner,
v.
GORSAGE, INC.,
dba Howard Jacobs Masonry,
Respondent.
(SH-87-088; CA A50317)

Judicial Review from Workers' Compensation Board.

Argued and submitted June 5, 1989.

John T. Bagg, Assistant Attorney General, Salem, argued the cause for petitioner. With him on the brief were Dave Frohnmayer, Attorney General, and Virginia L. Linder, Solicitor General, Salem.

James R. Watts, Portland, argued the cause for respondent. With him on the brief was Watts & Watts, Portland.

Before Graber, Presiding Judge, and Riggs and Edmonds, Judges.

RIGGS, J.

Reversed and remanded for reinstatement of citation and penalty.

RIGGS, J.

Accident Prevention Division (APD) seeks review of a Workers' Compensation Board order vacating a citation and penalty. We reverse and reinstate the citation and penalty.

APD cited defendant, a masonry contractor, for a violation of OAR 437-83-1959, a rule governing the use of scaffolding and ladders on construction sites. The rule requires:

> "Guardrails and toeboards shall be installed on all open sides and ends of platforms more than 10 feet above the ground or floor, except needle-beam, ladderjacks and float scaffolds. (see Rules 437-83-2446, 437-83-2496 and 437-83-2536)."

The Board held that APD should instead have cited OAR 437-83-2169, which provides:

> "Tubular welded frame scaffolds shall be equipped with guardrails as prescribed in rules 437-83-1959 through 437-83-1976."

The Board reasoned that APD erred in citing a general rule prescribing standards for all types of platforms, rather than the specific rule prescribing safety standards for tubular welded frame scaffolding, because,

> "where the specific standard [OAR 437-83-2169] addressed a specific condition (guardrails as *prescribed*), then it is not appropriate for the general standard [OAR 437-83-1959] to become applicable, and that is the situation in this case." (Emphasis in original.)

It vacated the citation and the penalty.

The rule of statutory construction that a specific rule controls over a general rule applies in a situation where there is a conflict or inconsistency between the two rules. ORS 174.020; *Davis v. Wasco Intermediate Education District*, 286 Or 261, 593 P2d 1152 (1979). There is no inconsistency or conflict between the two rules. The rule cited by APD, although in a section pertaining to all scaffolding and ladders, contains specific requirements necessary to the implementation of the rule that the Board concluded should have been cited, OAR 437-83-2169. Furthermore, OAR 437-83-2169 incorporates by reference the rule actually cited. Thus, the two rules are complementary rather than contradictory.

Given the language of the two rules at issue, citation of either rule would have been adequate to inform defendant of the violation with which he was charged. Accordingly, we hold that the Board erred in vacating the citation and the penalty.

Reversed and remanded for reinstatement of the citation and penalty.

IN THE COURT OF APPEALS OF THE STATE OF OREGON

ACCIDENT PREVENTION DIVISION,
Petitioner,
v.
BLISS,
dba Bliss Roofing Co.,
Respondent.
(SH 87-178; CA A50316)

Judicial Review from Workers' Compensation Board.

Argued and submitted June 5, 1989.

John T. Bagg, Assistant Attorney General, Salem, argued the cause for petitioner. With him on the brief were Dave Frohnmayer, Attorney General, and Virginia L. Linder, Solicitor General, Salem.

James R. Watts, Portland, argued the cause for respondent. With him on the brief was Watts & Watts, Portland.

Before Graber, Presiding Judge, and Riggs and Edmonds, Judges.

RIGGS, J.

Reversed and remanded for reinstatement of citation and penalty.

RIGGS, J.

Accident Prevention Division (APD) seeks review of a Workers' Compensation Board referee's order vacating a safety violation citation and penalty. We reverse and reinstate the citation and penalty.

APD cited defendant, a roofing contractor, for violating OAR 437-83-2519, which requires a catch platform below the working area of roofs of a particular height above the ground and having a particular slope. An inspection of the job site had revealed three employes installing roofing materials on a three-story house without either a catch platform or safety belts attached to a lifeline.[1] The inspector noted that "employes were exposed to a fall of 25 feet to soft mud below." APD assessed a penalty for that and two other violations that are not at issue in this appeal.

Defendant appealed the citation to the Hearings Division of the Workers' Compensation Board. In its

[1] OAR 437-83-2519 provides:

"A catch platform shall be installed below the working area of roofs more than 16 feet from the ground to eaves with a slope of greater than 4 inches in 12 inches without a parapet. In width, the platform shall extend 2 feet beyond the protection of the eaves and shall be provided with a guardrail, mid-rail, and toeboard.

"NOTE: This provision shall not apply where employes engaged in work on such roofs are protected by a safety belt attached to a lifeline."

amended opinion and order the Board found that the roof height and slope brought the project within OAR 437-83-2519 and that there was no catch platform or safety belt and lifeline protection. The Board also found that the cost of installing a catch platform for use in a single-family residential roofing project was $2,000 and that that cost is "prohibitive." It concluded that the "economic feasability [sic] defense has been established." It vacated the citation and penalty.

APD argues that the Board erred in finding economic infeasability a legitimate defense to a charge of violating OAR 437-83-2519. It also argues that, even if the defense were legitimate, no substantial evidence supports the referee's conclusion that defendant could not feasibly comply with OAR 437-83-2519.[2] Because we agree that there is no substantial

evidence supporting the Board's conclusion, we do not reach the question of the applicability of the economic infeasability defense to the regulation at issue.

Defendant Bliss testified regarding the costs involved:

> "If you were to use a metal one, a scaffolding plank, you're looking at, on a house this size, to set it up, probably two days for two guys, and I don't have a clue. Two thousand dollars, maybe, to set it up.
>
> "Q. And then the same to take it down, or does that include taking it down?
>
> "A. I'm just guessing."[3]

Even if defendant's guess were correct, there is no explanation of why that cost is prohibitive. There is no evidence of the total construction costs of the house; there is no evidence about whether a scaffold is reusable, either in part or totally; and there is no test or standard articulated that would be applicable in other cases alleging a violation of the same regulation. The referee's determination that compliance with the regulation would be economically infeasible appears simply to be an *ad hoc* view that the safety measure is too expensive. Accordingly, we reverse the order and reinstate APD's citation and penalty.[4]

The purposes of the Oregon Safe Employment Act are to provide working conditions as safe and as healthful as possible, to preserve human resources and to reduce the burden created by occupational injury and disease. ORS 654.003. The Board's order could reduce protection to the worker, contrary to the act's purpose, without there being substantial evidence that compliance with the regulations is economically infeasible.

Reversed and remanded for reinstatement of the citation and penalty.

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[2] Petitioner also assigns as error the Board's conclusion that brackets and toeboards are an acceptable alternative safety measure. Because we reverse, we do not consider that assignment of error.

[3] Defendant also testified that he believed that the use of catch platforms would drive the cost of houses up because of increased costs for liability insurance and workers' compensation coverage. That statement defies logic.

[4] The parties stipulated at the hearing that, if a violation were found, a $65 penalty would be appropriate. Therefore, we reinstate that penalty, despite the fact that it was originally imposed for all three cited violations combined.

IN THE COURT OF APPEALS OF THE STATE OF OREGON

In the Matter of the Compensation of David S. Zimmerman, Claimant.

AGRIPAC, INC., et al,
Petitioners,

v.

ZIMMERMAN,
Respondent.

(86-15055; CA A49347)

Judicial Review from Workers' Compensation Board.

Argued and submitted March 10, 1989.

Jerald P. Keene, Portland, argued the cause for petitioners. With him on the brief was Roberts, Reinisch & Klor, P.C., Portland.

J. Michael Alexander, Salem, argued the cause for respondent. With him on the brief was Burt, Swanson, Lathen, Alexander & McCann, Salem.

Before Graber, Presiding Judge, and Riggs and Edmonds, Judges.

EDMONDS, J.

Reversed and remanded for reconsideration.

Riggs, J., dissenting.

EDMONDS, J.

Employer seeks review of an order of the Workers' Compensation Board that reversed the referee and set aside its denial of compensability. We review for substantial evidence and errors of law. ORS 656.298(6); *Armstrong v. Asten-Hill Co.,* 90 Or App 200, 206, 752 P2d 312 (1988).

Claimant injured his left knee in October, 1986, when he jumped approximately five feet to the ground from a loading dock of employer. The injury occurred as claimant was leaving work to go home after completing his shift. He jumped from the dock rather than use a nearby flight of stairs. The issue is whether his injury is compensable.

To be compensable, an injury must arise out of and in the course of employment. *Former* ORS 656.005(8)(a).[1] "If the injury has sufficient work relationship, then it arises out of and in the course of employment * * *." *Rogers v. SAIF,* 289 Or 633, 643, 616 P2d 485 (1980). An on-premises injury has sufficient work relationship if it occurs while the employe is leaving work, unless the employe was engaged in conduct not expressly or impliedly allowed by the employer. *Clark v. U.S. Plywood,* 288 Or 255, 260-61, 266-67, 605 P2d 265 (1980); *see*

also Bailey v. Peter Kiewit and Sons, 51 Or App 407, 410-11, 626 P2d 3 (1981).

The Board concluded that *Clark v. U.S. Plywood, supra,*[1] does not apply to an employe who is engaged in "going and coming activities." *Clark* is not so limited.[2] The Board made an error of law in failing to apply *Clark.*

Because the Board did not apply the standard contained in *Clark,* it also did not make all of the necessary findings. Claimant's on-premises injury occurred as he was leaving work. Therefore, whether his injury is compensable turns on whether employer expressly or impliedly allowed him to jump from the dock. The Board made no finding on that question.[3]

Reversed and remanded for reconsideration.

RIGGS, J., dissenting.

Under *Clark v. U.S. Plywood,* 288 Or 255, 266-67, 605 P2d 265 (1980), claimant's injury was compensable if his conduct was expressly or impliedly allowed by employer. "For example, where an employer acquiesces in a course of on-premises conduct, compensation is payable for injuries which might be sustained from that activity." 288 Or at 267.

The Board found that "employer had never

---

[1] Because claimant's injury occurred in October, 1986, *former* ORS 656.005(8)(a) is applicable, rather than ORS 656.005(7)(a), which was not in force in its current form until 1987. *See* ORS 656.202(2).

Former ORS 656.005(8)(a) provided:

"A 'compensable injury' is 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. However, 'compensable injury' does not include injury to any active participant in assaults or combats which are not connected to the job assignment and which amount to a deviation from customary duties."

ORS 656.005(7)(a) currently provides:

"A 'compensable injury' is 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. However, 'compensable injury' does not include:

"(A) Injury to any active participant in assaults or combats which are not connected to the job assignment and which amount to a deviation from customary duties; or

"(B) Injury incurred while engaging in or performing, or as the result of engaging in or performing, any recreational or social activities solely for the worker's personal pleasure."

[2] The express or implied allowance test applies to

"[on-premises i]njuries sustained while engaged in * * * incidental activities not directly involved with the performance of the appointed task, such as preparing for work, going to or from the area of work, eating, rest periods, going to the bathroom, or getting fresh air or a drink of water." *Clark v. U.S. Plywood, supra,* 288 Or at 260.

[3] The only findings of fact that the Board made relating to the issue are these:

"The employer had never instructed claimant not to jump from the dock and claimant had done so on several occasions in the presence of supervisory personnel without reprimand. An employee manual issued by the employer and read by claimant prior to the date of the injury prohibited 'unsafe acts' on the employer's premises. The manual, however, did not expressly designate jumping from a loading dock as an 'unsafe act.' "

instructed claimant not to jump from the dock and claimant had done so on several occasions in the presence of supervisory personnel without reprimand." That finding of employer's acquiescence in claimant's conduct is sufficient to support compensation under *Clark*. Because the finding is supported by substantial evidence, I would affirm.

I dissent.

IN THE COURT OF APPEALS OF THE STATE OF OREGON

CARR,
Appellant,
v.
U S WEST DIRECT COMPANY et al,
Respondents.
(A8703-01982; CA A49675)

Appeal from Circuit Court, Multnomah County.

William S. McLennan, Judge.

Argued and submitted April 28, 1989.

Richard C. Busse, Portland, argued the cause for appellant. With him on the briefs was Donald B. Potter, Portland.

Susan M. Hammer, Portland, argued the cause for respondent U S West Direct Company. With her on the brief were Charles F. Adams and Stoel Rives Boley Jones & Grey, Portland.

No appearance for respondent Jeff Pickthorn.

Before Buttler, Presiding Judge, and Warren and Rossman, Judges.

WARREN, J.

Affirmed.

WARREN, J.

Plaintiff appeals a judgment dismissing her claim entitled "invasion of privacy" against defendants U S West Direct Company (U S West) and Pickthorn and granting summary judgment to U S West on her claims of intentional infliction of emotional distress, assault, battery and negligence. We affirm.

We summarize the evidence on summary judgment in the light most favorable to plaintiff. *Seeborg v. General Motors Corporation,* 284 Or 695, 699, 588 P2d 1100 (1978).[1] Plaintiff worked as an outside sales representative for U S West. At the relevant time, Pickthorn was her supervisor. As a part of her job, plaintiff called on businesses to solicit ads. It was common for supervisors to accompany sales people, and on June 20, 1986, plaintiff invited Pickthorn to join her for her appointments. In the course of that day, Pickthorn sexually harassed, assaulted and, finally, raped plaintiff. He continued to harass

[1] We disregard evidence not admissible on a summary judgment motion. ORCP 47D.

her sexually in the office after that time. She did not report the incidents until September, 1986, because she believed that the company had a *de facto* policy to ignore male supervisors' harassment of female employes, and she feared reprisal or the loss of her job.

The record on summary judgment shows that, in October, 1983, plaintiff had been sexually harassed by another manager and that approximately six weeks later she had reported that incident to fellow workers. They suggested that she contact the union, which she or someone else did. The company acted on the union's complaint the following October.

Plaintiff testified in her deposition that she and other women are of the opinion that it is difficult to have anything done by U S West about sexual harassment. She testified further that, during her time with the company, she has heard the remark, "What goes on the road stays on the road," from managers and sales people alike, and that she believes, based only on what she has heard from other workers, that it reflects a corporate policy that U S West will not concern itself with sexual harassment of female employes. The evidence shows

that Pickthorn and U S West's Director of Human Resources were familiar with that expression.

Evidence also shows that U S West had an official policy that sexual harassment and discrimination would not be tolerated, that it conducted regular training for its employes and supervisors concerning harassment and that Pickthorn had participated in that training. Early in 1985, U S West learned of alleged sexual harassment by Pickthorn while managing a telephone sales group. After investigation, the company found that he had engaged in inappropriate sexual "horseplay." U S West disciplined Pickthorn by denying him a bonus, not permitting him to attend a high achiever's holiday, transferring him laterally to an outside sales office, placing him on one-year probation, beginning March, 1985, and warning him that further complaints could result in his discharge.

During the probationary period, Pickthorn was under the supervision of Doyle, who had frequent contacts with him and spoke with his sales crew and other managers to assure that his conduct was professional. There were no reports of inappropriate behavior. Plaintiff asked to be on Pickthorn's crew, and she worked for him from August, 1985, to June, 1986, without incident. She reported to Doyle that Pickthorn was an excellent manager. She testified in deposition that U S West could have had no knowledge that Pickthorn was dangerous or that he would rape her or any other employe. In a later affidavit, she stated that she believed that U S West knew that Pickthorn had a violent temper and was intimidating. Plaintiff's September, 1986, report of harassment and rape was the first report of misconduct that U S West had received regarding Pickthorn since he began probation. Her charges were investigated, and Pickthorn was fired.

Plaintiff's first complaint contained a claim entitled "invasion of privacy" against both defendants. The trial court struck it on the theory that it did not state a claim. Plaintiff's

amended complaint contains three claims entitled "intentional infliction of emotional distress." The first, against Pickthorn and U S West, is based solely on Pickthorn's conduct, and plaintiff alleges that U S West is liable on a theory of *respondeat superior*. The second claim alleges that U S West is directly liable, because it has a *de facto* policy of ignoring

sexual harassment of women. The third claim alleges that U S West is directly liable, because it had a *de facto* policy to overlook harassment and nevertheless transferred Pickthorn to a location where it would be easy for him to engage in sexual harassment. Plaintiff also pleaded claims for assault and battery against both Pickthorn and U S West, again asserting that U S West's liability arises on a theory of *respondeat superior*. The sixth claim, against U S West directly, is for negligence. The trial court granted summary judgment for U S West on each claim, either on the theory that it is exempt from tort liability pursuant to ORS 656.018[2] or that there is no factual basis for direct liability.

The first question is whether, under the workers' compensation law, U S West is exempt from liability on any of the claims. ORS 656.018(1) makes the provisions of ORS chapter 656 exclusive with respect to liability arising out of a *compensable* injury. In determining whether the injury is compensable, we examine the relationship between the injury and the employment: Was the "work connection" sufficient?[3]

Rogers v. SAIF, 289 Or 633, 616 P2d 485 (1980).

The first significant fact is that claimant was injured in the course of her employment, *i.e.*, during the time, at the place and in the circumstances of employment. She was performing her job when she was assaulted. This factor weighs in favor of compensability; however, it is not by itself determinative. Also relevant is the question of "causation," *i.e.*, whether the injury "arose out of" the employment. Here the

[2] ORS 656.018 provides:

"(1)(a) The liability of every employer who satisfies the duty required by ORS 656.017(1) is exclusive and in place of all other liability arising out of compensable injuries to the subject workers, the workers' beneficiaries and anyone otherwise entitled to recover damages from the employer on account of such injuries or claims resulting therefrom, specifically including claims for contribution or indemnity asserted by third persons from whom damages are sought on account of such injuries, except as specifically provided otherwise in ORS 656.001 to 656.794.

"* * * * *

"(2) The rights given to a subject worker and the beneficiaries of the subject worker for compensable injuries under ORS 656.001 to 656.794 are in lieu of any remedies they might otherwise have for such injuries against the worker's employer under ORS 654.305 to 654.335 or other laws, common law or statute, except to the extent the worker is expressly given the right under ORS 656.001 to 656.794 to bring suit against the employer of the worker for an injury.

"(3) The exemption from liability given an employer under this section is also extended to the employer's insurer, the department, and the employes, officers and directors of the employer, the employer's insurer and the department except that the exemption from liability shall not apply:

"(a) Where the injury is proximately caused by wilful and unprovoked aggression by the person otherwise exempt under this subsection[.]"

[3] In this context, the question of compensability is not a "matter concerning a claim" over which the Workers' Compensation Board has exclusive jurisdiction. ORS 656.704. Additionally, in view of the undisputed evidence, we can decide the question as a matter of law.

Employer contends that plaintiff has raised the question of compensability for the first time on appeal. We conclude, however, that employer raised the issue at trial when it asserted that ORS 656.018 applies.

connection to the work is weak. The source of the injury bears little or no relationship to the employment. There is no evidence that the assaults were provoked by anything related to the work. *See Youngren v. Weyerhaeuser Co.*, 41 Or App 333, 597 P2d 1302, *rev den* 288 Or 81 (1979). There is no evidence that the nature of the job or the job environment created or enhanced the risk of assault. The fact that the employment placed plaintiff and Pickthorn together is not, in itself, enough.[4] *See City of Richmond v. Braxton*, 290 Va 161, 335 SE2d 259 (1985). An employer is not subject to the workers' compensation law for all injuries to an employe irrespective of the cause merely because the employe is injured while working at the place of employment. There must be some causal link between the occurrence of the injury and a risk connected with the employment. *Phil A. Livesley Co. v. Russ*, 296 Or 25, 672 P2d 337 (1983). That link has not been established here, and we conclude, therefore, that the evidence on summary judgment does not compel the conclusion that the occurrence was covered by the workers' compensation law.[5] U S West is therefore not entitled to summary judgment on the ground that it is exempt from liability pursuant to ORS 656.018.

Contrary to defendant's contention, *Palmer v. Bi-Mart*, 92 Or App 470, 758 P2d 888 (1988), does not require a different result. We held that the Workers' Compensation Act does not operate to the exclusion of the statutory discrimination law, ORS 659.121. We also held that the fact that the plaintiff had an accepted workers' compensation claim for injuries arising out of sexual harassment did not prevent her

from bringing a statutory discrimination claim and a common law claim for intentional infliction of emotional distress against her employer and supervisor. Because the compensation claim had been accepted, we assumed, for the purpose of our analysis, that it was compensable. We did not decide whether, under the circumstances of that case, the claim was, in fact, compensable. The issue was not before us.

We next consider whether, as a matter of law, U S West could be vicariously liable for the injuries sustained by plaintiff. In order for an employer to be vicariously liable for the intentional tortious conduct of an employe, the employe causing the harm must be acting within the time and space limits of the employment and must be motivated at least partially by the purpose to serve the employer. The work must be of a kind that the employe was hired to perform. *See G. L. v. Kaiser Foundation Hospitals, Inc.*, 306 Or 54, 757 P2d 1347 (1988). Here, the evidence on summary judgment does not indicate that Pickthorn was acting other than for personal motives. There is no indication that the employment was even remotely the cause of his conduct. The trial court correctly granted summary judgment to U S West on the claims of intentional infliction of emotional distress, assault and battery and correctly dismissed the claim of "invasion of privacy" against U S West. All of those claims were based on a theory of vicarious liability.

[4] If we had held otherwise on the negligence claim, *see* 98 Or App at 37 (1989), there might be an argument that U S West's negligence created an increased risk.

[5] Contrary to U S West's contention in its brief, whether plaintiff suffered from the *type* of injury for which compensation may be awarded is not determinative of whether the particular injury is compensable.

The only question remaining is whether the evidence on summary judgment creates a question of fact concerning whether U S West is directly liable on the other three tort claims. The two claims for intentional infliction of emotional distress are based on the allegations that U S West maintained a *de facto* policy of allowing sexual harassment of female employes and transferred Pickthorn to a new location even though it was aware of his tendency to take advantage of that policy. We conclude that there is no evidence to support those allegations. Plaintiff relies on the evidence that individuals who worked for U S West, including Pickthorn, were familiar with and repeated the expression "What goes on the road stays on the road" and that *plaintiff* interpreted that expression to state a policy that the company would ignore sexual harassment. What plaintiff believes is not evidence, however, that the expression, whatever it meant, was a statement of corporate policy.

The negligence claim alleges that U S West failed to train, control or supervise Pickthorn and that it was negligent in retaining him and in maintaining a sexually hostile workplace. Plaintiff's argument consists only of a general statement that the record supports the allegations. The evidence most favorable to plaintiff shows that, when U S West learned of Pickthorn's conduct while managing a telephone sales group in 1985, it disciplined him, transferred him to a new location and placed him on probation under the supervision of Doyle, with whom he had frequent contact. The reports that Doyle received concerning Pickthorn's conduct were positive, including a report from plaintiff that Pickthorn was an excellent manager. Plaintiff testified by deposition that U S West could not have known that Pickthorn was dangerous or that he would rape her or any other employe. The only evidence to the contrary is plaintiff's later affidavit that she believed that U S West knew that Pickthorn had a violent temper and was intimidating. That evidence does not alone create a question of fact for the jury. *See Henderson-Rubio v. May Dept. Stores,* 53 Or App 575, 632 P2d 1289 (1981).

We hold that the evidence shows, as a matter of law, that U S West's conduct did not fall below the standard of acceptable conduct and that the trial court therefore correctly granted summary judgment to U S West on the negligence claim. *Stewart v. Jefferson Plywood Co.,* 255 Or 603, 469 P2d 783 (1970).

With regard to the invasion of privacy claim against Pickthorn, we conclude that the trial court erred in striking it for failure to state a claim, because the allegations at least stated a claim for battery. The error was not prejudicial, however, because the allegations are identical to the allegations in the battery claim that were not stricken.[6]

Affirmed.

[6] In reaching our conclusion that the allegations duplicate the "battery" claim, we disregard the conclusory allegation: "Defendant's conduct unreasonably intruded into Plaintiff's private affairs or concerns, and Defendants are liable to her for invasion of privacy." *See Holden v. Pioneer Broadcasting Co., et al,* 228 Or 405, 417-18, 365 P2d 845, *cert den* 370 US 157 (1961).

IN THE COURT OF APPEALS OF THE STATE OF OREGON

In the Matter of the Compensation of Manuel Garcia-Maciel, Claimant.

AMFAC, INC.,
Respondent,

v.

GARCIA-MACIEL et al,
Respondents,

and

SCHWABE, WILLIAMSON & WYATT,
Petitioners.

(86-07831, 86-07830; CA A49398 (Control))

In the Matter of the Compensation of Jane E. Stanley, Claimant.

K-MART CORP.,
Respondent,

v.

STANLEY,
Respondent,

and

SCHWABE, WILLIAMSON & WYATT,
Petitioners.

(86-11196; CA A49399)

In the Matter of the Compensation of Phillip Carpenter, Claimant.

MONTGOMERY WARD & CO. et al,
Respondents,

v.

CARPENTER,
and

SCHWABE, WILLIAMSON & WYATT,
Petitioners.

(86-03489; CA A49400)

In the Matter of the Compensation of Elmer Jacobs, Claimant.

WEYERHAEUSER COMPANY,
Respondent,

v.

JACOBS,
Respondent,

and

SCHWABE, WILLIAMSON & WYATT,
Petitioners.

(86-07590; CA A49401)
(Cases consolidated)

Judicial Review from Workers' Compensation Board.

Argued and submitted June 2, 1989.

Mildred J. Carmack, Portland, argued the cause for petitioners. On the brief were Schwabe, Williamson & Wyatt and Ridgway K. Foley, Jr., P.C., Portland.

Robert K. Udziela, Portland, waived appearance for respondents Manuel Garcia-Maciel and Phillip Carpenter.

Robert Wollheim, Portland, waived appearance for respondent Jane E. Stanley.

No appearance for respondents Amfac, Inc., Oregon Garden Products, K-Mart Corp., Montgomery Ward & Co., Aetna Casualty Co., Weyerhaeuser Company and Elmer Jacobs.

Before Richardson, Presiding Judge, and Newman and Deits, Judges.

RICHARDSON, P. J.

Reversed and remanded.

RICHARDSON, P. J.

Petitioners are attorneys. They seek review of the Workers' Compensation Board's denial of their requests for approval of "client-paid" attorney fees in four Board proceedings[1] in which petitioners represented employers or self-employed insurers. *See* ORS 656.388(1). The Board based the denial on petitioners' failure to file their requests within 15 days after the last brief was filed in each of the proceedings. OAR 438-15-027(1)(d) provides:

> "A statement of services for proceedings on Board review of a referee's order shall be filed within 15 days after the filing of the last brief to the Board."

Notice of proposed rulemaking was given on November 15, 1987, and the rule was promulgated on December 18 and took effect on January 1, 1988. The last brief in each of the proceedings was filed even before the proposal, let alone the adoption, of the rule—the most recent on October 14, 1987. The Board concluded, however, that the rule should be applied retroactively, and it refused the requests. Petitioners assign error to the retroactive application of the rule.

The threshold question is whether we have jurisdiction.[2] Petitioners seek direct review of the Board's orders pursuant to ORS 656.298(1). ORS 656.388(2) provides:

> "If an attorney and the referee or board cannot agree upon the amount of the fee, each forthwith shall submit a written statement of the services rendered to the presiding judge for the circuit court in the county in which the claimant resides. The judge shall, in a summary manner, without the payment of filing, trial or court fees, determine the amount of such fee.

[1] The four are consolidated on review.

[2] We raised that question *sua sponte*, and petitioners filed a memorandum in response before filing their brief. We then made a tentative decision that we had jurisdiction, subject to reexamination in this opinion.

This controversy shall be given precedence over other proceedings."

See Greenslitt v. City of Lake Oswego, 305 Or 530, 754 P2d 570 (1988).

Petitioners argue that ORS 656.388(2) does not give

the circuit court jurisdiction here, because, *inter alia,* these are not disputes over the *amount* of attorney fees and, therefore, the Board's order is reviewable by us under ORS 656.298(1). We agree with that conclusion. The only decision that ORS 656.388(2) assigns to the circuit court is the "amount of the fee," and the only bases for decision that the statute specifies is a "written statment[s] of the services rendered." A circuit court proceeding is required to be summary in nature. ORS 656.388(2) was not designed for or intended to apply to proceedings such as this, which happen to involve attorney fees but which turn on legal or factual questions that go well beyond disagreement over the amount of fees to be allowed.

On the merits, we agree with petitioners. As applied to these cases, the Board's retroactive application of the rule would disallow attorney fees to petitioners unless they had performed the impossible—or at least purely fortuitous—act of complying with a rule that did not exist at the time compliance was putatively required. Under the circumstances, that application of the rule "is unreasonable in its prejudice to petitioners." *Gooderham v. AFSD,* 64 Or App 104, 109, 667 P2d 551 (1983).

Reversed and remanded.[3]

[3] Petitioners ask that we "reverse the Board's orders and award the full amount of attorney fees requested." We do not agree that the ultimate questions of the amount of attorney fees to be awarded, or their awardability, are now to be decided by us. The only issue that petitioners' assignment raises, and that we decide, is whether the 15-day rule may be applied retroactively.

IN THE COURT OF APPEALS OF THE STATE OF OREGON

In the Matter of the Compensation of John L. Partible, Claimant.

SAIF CORPORATION et al,
Petitioners,

v.

PARTIBLE,
Respondent.

(WCB 87-14305; 87-08931; CA A50886)

Judicial Review from Workers' Compensation Board.

Argued and submitted July 10, 1989.

John A. Reuling, Jr., Assistant Attorney General, Salem, argued the cause for petitioners. With him on the brief were Dave Frohnmayer, Attorney General, and Virginia L. Linder, Solicitor General, Salem.

L. Leslie Bush, Portland, argued the cause for respondent. With him on the brief was Tamblyn & Bush, Portland.

Before Buttler, Presiding Judge, and Warren and Rossman, Judges.

WARREN, J.

Affirmed.

WARREN, J.

Claimant suffered a low back injury in 1980 while working for employer. Employer accepted the claim. In July, 1986, while participating in an authorized training program as a short order cook, claimant sustained an injury to his neck and upper back. Employer accepted responsibility for the injury. The low back claim was closed in January, 1987, and the determination order included an award for temporary total disability for the entire training period.[1]

The question is whether the 1986 injury, conceded by employer to be a new injury and not merely an aggravation of the original injury, should be treated as a new and independent injury claim for the purpose of calculating the period of claimant's aggravation rights. The Board ruled that it should be. Employer contends that the injury, compensable only because it is a natural and direct consequence of the original injury, *see Wood v. SAIF,* 30 Or App 1103, 569 P2d 648 (1977), *rev den* 282 Or 189 (1978), should be processed as part of the original claim and that claimant's aggravation rights should be calculated from the date of the original injury.

In *Wood,* we addressed the question of the compensability of an injury experienced during vocational rehabilitation. We reasoned that the "concept of compensability for injuries sustained in the course of and arising out of employment includes injuries during activities which are a direct and natural consequence of the original injury." 30 Or App at 1108. We concluded that an injury sustained during an authorized period of vocational rehabilitation was a "direct and natural consequence" of the original injury and therefore compensable.

Whether an injury experienced during vocational rehabilitation is a direct and natural consequence of the original injury is relevant to the question of causation and is determinative of the question of whether the original employer is responsible for the injury. Employer does not dispute that the injury experienced by claimant is related to the original injury and that it is responsible. It argues only that, from the claims processing standpoint, the injury should be treated as an

aggravation of the original injury. We agree with the Board that that is a question of fact to be evaluated in each case. The fact that an injury suffered during vocational rehabilitation is compensable because it is a direct and natural consequence of the original injury does not necessarily mean that it is com-

[1] The rate of compensation for temporary total disability is not at issue.

pensable for purposes of claims processing as an aggravation of the original injury. The claim should be processed either as an aggravation or as a new injury, depending on the facts of the particular case. Substantial evidence supports the Board's finding that the July, 1986, event was a new injury. Accordingly, it should be processed as a new injury claim, with all the attendant attributes.

Affirmed.

IN THE COURT OF APPEALS OF THE STATE OF OREGON

In the Matter of the Compensation of Lucy Linn, Claimant, and
In the Matter of the Complying Status of Lee Ann Clark, dba Shear Sunshine, Employer.

CLARK,
dba Shear Sunshine,
Petitioner,

v.

LINN et al,
Respondents.

(85-07139; CA A50436)

Judicial Review from Workers' Compensation Board.

Argued and submitted July 10, 1989.

Richard Wm. Davis, Portland, argued the cause for and filed the brief for petitioner.

Robert E. Nelson, Gresham, argued the cause and filed the brief for respondent Lucy Linn.

John A. Reuling, Jr., 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.

BUTTLER, P. J.

Reversed and remanded for determination of compensability.

BUTTLER, P. J.

Employer seeks review of an order of the Workers' Compensation Board determining that she is a noncomplying employer and holding that she is not entitled to contest the compensability of the claim, because she failed to deny it properly. We reverse and remand.

Claimant injured her back in January, 1985, while working as a dog groomer, and filed a claim in March, 1985. On April 4, 1985, employer indicated on the form that the claim was denied. On April 17, 1985, the Workers' Compensation Department issued an order declaring employer to be a

noncomplying employer. ORS 656.052(2). Employer appealed the Department's order by a letter dated April 25, 1985, contesting the determination that she was noncomplying and asserting that the claim was not compensable. Employer mailed a copy of the letter to claimant, but did not advise her of her hearing rights on a denied claim. ORS 656.262(8). On May 2, 1985, SAIF Corporation accepted the claim and notified employer by letter that she had a right, pursuant to ORS 656.283(1), to request a hearing if she believed that the claim was not compensable. OAR 436-80-060(1). On May 17, 1985, employer requested a hearing on the question of compensability. She did not mail a copy of that request to claimant; however, claimant and her attorney appeared at, and participated in, the hearing.

The referee determined that employer was a noncomplying employer and, finding that claimant was not credible, decided that the claim was not compensable. He set aside SAIF's acceptance. Claimant appealed to the Board. Employer did not challenge the referee's determination that she is a noncomplying employer. She argued only that the claim is not compensable. The Board did not reach the merits of the question of compensability. It determined only that, because employer had never sent claimant a notice advising her of her right to a hearing on a denied claim, employer had never properly denied the claim and could not now contest its compensability. It held that claimant was entitled to compensation in spite of the referee's finding that the claim was not compensable.

In reaching its result, the Board relied on our opinion in *Derryberry v. Dokey,* 91 Or App 533, 756 P2d 1255, *rev den*

306 Or 661 (1988). There, the claimant contended that *Bauman v. SAIF,* 295 Or 788, 670 P2d 1027 (1983), prevented the noncomplying employer from denying a claim that SAIF, acting pursuant to its statutory obligation to process the claim, had accepted. We did not decide that question, because neither the noncomplying employer nor SAIF had denied the claim; therefore, we held that SAIF's acceptance stood.

It is apparent from our opinion in *Derryberry v. Dokey, supra,* that the statutory scheme relating to the processing of claims against a noncomplying employer was not argued or brought to our attention or recognized by us. Here, it has been reviewed thoroughly by both employer and SAIF, which agrees with employer that the Board erred. It is clear that the statutes and administrative rules provide that it is SAIF's responsibility to accept or deny a claim against a noncomplying employer. If SAIF denies the claim, the claimant has the right to a hearing; if it is accepted, the employer has that right.

ORS 656.054(1) provides:

> "A compensable injury to a subject worker while in the employ of a noncomplying employer is compensable to the same extent as if the employer had complied with ORS 656.001 to 656.794. * * * A claim for compensation made by such a worker shall be processed by the State Accident Insurance Fund Corporation in the same manner as a claim made by a worker employed by a carrier-insured employer * * *."

At the relevant time, OAR 436-80-010 provided in part:

"When it comes to the attention of [the Compliance Section of the Workers' Compensation Division of the Department of Insurance and Finance] that an employer, who is a subject employer, had failed to provide workers' compensation coverage for subject workers, Compliance shall issue an order, stating the pertinent facts, and declaring the employer to be a noncomplying employer."

OAR 436-80-060(1) provided:

"When Compliance issues an order under OAR 436-80-010 declaring an employer a noncomplying employer, if a subject worker has filed a claim for an injury sustained during the period of noncompliance while the worker was employed by such employer:

"(a) Compliance shall refer the claim with a copy of the

order and the results of its investigation to the [State Accident Insurance] Fund for processing as required by ORS 656.054;

"(b) Compliance shall inform the worker that the claim has been referred to the Fund;

"(c) When the Fund accepts or denies the claim, it shall notify the claimant, employer and compliance of its action within the time required by ORS 656.262; and

"(d) The notice shall also inform each party of the right to a hearing under ORS 656.283 on questions of compensability."

Once the Compliance Section determined that employer was a noncomplying employer, SAIF was required to accept or deny the claim. ORS 656.054; OAR 436-80-60. If SAIF denied the claim, it was required to inform claimant of her hearing rights. ORS 656.262(8); OAR 436-80-060. If SAIF accepted the claim, as it did here, it was required to notify employer of her right to a hearing under ORS 656.283(1)[1] to contest compensability. OAR 436-80-060(1)(d). Employer requested a hearing pursuant to ORS 656.283 and is entitled to have the question of compensability determined. Whether or not employer properly denied the claim pursuant to ORS 656.262 is irrelevant; that was SAIF's responsibility. Her right to litigate the compensability of the claim does not arise from ORS 656.262(8), but from ORS 656.283(1) and OAR 436-80-060(1)(d). To the extent that *Derryberry v. Dokey, supra,* suggests a contrary result, it is disapproved.[2] We conclude, therefore, that the Board erred in failing to address the question of compensability.

Reversed and remanded for determination of compensability.

[1] ORS 656.283(1) provides:

"Subject to subsection (2) of this section and ORS 656.319, any party or the director may at any time request a hearing on any question concerning a claim."

[2] We note a factual distinction from *Derryberry,* in which a copy of the employer's letter to the Compliance Division was not sent to the claimant; here, employer sent a copy of its letter contesting compensability to claimant. Our rationale, however, makes the distinction immaterial.

IN THE SUPREME COURT OF THE STATE OF OREGON

In the Matter of the Compensation of William M. Albrecht, Claimant.

TRI-MET, INC.,
Respondent on Review,

v.

ALBRECHT,
Petitioner on Review.

(WCB 86-02160; CA A46942; SC S36036)

In Banc

On review from the Court of Appeals. *

Argued and submitted June 14, 1989.

Merrill Schneider, Portland, argued the cause and filed the petition for petitioner on review.

Scott H. Terrall, Portland, argued the cause for respondent on review. On the response to the petition for review was Eric R. Miller, Portland.

Arthur C. Johnson and Douglas G. Schaller, of Johnson, Clifton, Larson & Bolin, Eugene, filed a brief *amicus curiae* on behalf of the Oregon Trial Lawyers Association.

Thomas Michael Cooney and Connie K. Elkins, of Cooney, Moscato & Crew, P.C., Portland, filed a brief *amicus curiae* on behalf of the Oregon Medical Association.

Jerald P. Keene, of Roberts, Reinisch & Klor, P.C., Portland, filed a brief *amicus curiae* on behalf of the Association of Workers' Compensation Defense Attorneys, Associated Oregon Industries, and Oregon Self-Insurers Association.

LINDE, J.

The decision of the Court of Appeals is reversed, and the decision of the Workers' Compensation Board is reinstated.

* Judicial review of order of Workers' Compensation Board. 95 Or App 155, 768 P2d 421 (1989).

LINDE, J.

The Workers' Compensation Law requires that a claimant submit to a requested medical examination and that the claimant's rights to compensation may be suspended if the claimant refuses to submit to or obstructs the medical examination. ORS 656.325(1). In the present dispute over the extent of claimant's permanent partial disability, claimant consented to an examination by designated physicians but insisted on the presence of his lawyer at the examination. The physicians refused to examine claimant with the lawyer present, and claimant's employer asserted that claimant's demand constituted an obstruction of the examination requiring suspension of his rights to compensation. The referee

rejected the employer's objection and made an award, and the Workers' Compensation Board affirmed. The Court of Appeals reversed the award and remanded the claim to the referee, holding that it was an abuse of discretion to allow claimant's demand for his lawyer's presence at a medical examination. *Tri-Met, Inc. v. Albrecht,* 95 Or App 155, 768 P2d 421 (1989). We reverse the decision of the Court of Appeals and reinstate the board's award.

ORS 656.325(1)(a) provides:

> "Any worker entitled to receive compensation under ORS 656.001 to 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. However, no more than three examinations may be requested except after notification to and authorization by 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."[1]

The Court of Appeals omitted any reference to its scope of review of the Workers' Compensation Board's decision. Instead, the court analogized the case to a civil action governed by ORCP 44A.[2] The court expressed its reasons why the presence of an attorney at a medical examination might affect the "neutral setting" and the "objective environment" of an independent medical examination and why these reasons should apply in workers' compensation cases. One of the briefs *amicus curiae* informs us that we are being invited "to participate in a feud." If so, we are grateful, as the Court of Appeals should have been, that what the brief describes as "the newest pitched battle" in the feud is not properly fought on our turf.

The Workers' Compensation Board is not a court; it is an administrative agency whose orders deciding claims the Court of Appeals reviews pursuant to the Administrative Procedure Act, ORS 183.482.[3] *See* ORS 656.298. The same *amicus*

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[1] Because neither party's brief, petition, or response quoted the statute, we once again draw counsels' attention to ORAP 7.24:

> "If an appeal involves an ordinance, charter, statute, constitutional provision, regulation or administrative rule, so much of the provision as relevant shall be set forth verbatim with proper citation. If lengthy, such matter should be appended or footnoted and need not be set out verbatim if it appears in another brief in the case and is cross-referenced appropriately."

[2] Under ORCP 44A, the trial court decides the conditions under which a medical examination is to take place. The rule provides:

> "When the mental or physical condition or the blood relationship of a party, or of an agent, employee, or person in the custody or under the legal control of a party (including the spouse of a party in an action to recover for injury to the spouse), is in controversy, the court may order the party to submit to a physical or mental examination by a physician or to produce for examination the person in such party's custody or legal control. The order may be made only on motion for good cause shown and upon notice to the person to be examined and to all parties and shall specify the time, place, manner, conditions, and scope of the examination and the person or persons by whom it is to be made."

also points out that independent medical examinations can and sometimes do arise before any occasion for a hearing on a claim. An administrative rule, contemplated by ORS 656.325(1), may provide how that examination is to be conducted. *See* OAR 436-60-090 *et seq.* In the absence of a valid rule, whether a worker "refuses to submit to any such examination" or "obstructs the same" so as to justify suspension of compensation are questions to be decided in the course of claims in which an employer or insurer or the director raises this issue.

We see no basis to hold that the board errs as a matter of law if it finds that a worker did not obstruct an independent medical examination by demanding to take along his lawyer. Nor do we see the board's decision as an exercise of agency "discretion." ORS 656.325(1) leaves the director discretion whether to consent to a suspension of compensation, but the board's decision whether a refusal has occurred is not an exercise of "discretion." The worker's conduct may or may not be a refusal to submit to or an obstruction of the examination depending on the nature of the examination, the intended conduct of counsel, and other circumstances, again assuming no failure to comply with a valid rule. The board may find the same insistence on the presence of a lawyer obstructive in one examination (perhaps, for instance, an examination depending on tests to be taken by the worker in silence and concentration) and not in another (for instance, the observation of technological examinations such as x-rays or blood tests). Unless defined by rules, refusal or obstruction is a finding of fact to be made on the evidentiary record and to be reviewed for substantial evidence. ORS 183.482(8)(c). In short, the forum for the "feud" is either the director or the Workers' Compensation Board, if not the legislature. The Court of Appeals erred in substituting its judgment for that of the board.

Here the employer asserted that the claimant "obstructed" the examination solely on the objections of the selected physician to conduct the examination in the presence of claimant's lawyer. The physician gave this explanation:

> "A. It is a very simple thing. It is a medical examination. My position isn't — is not that of an advocate. I'm a physician. My purpose is to take a history under the best circumstances...

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[3] ORS 183.482(8) provides:

"(a) The court may affirm, reverse or remand the order. If the court finds that the agency has erroneously interpreted a provision of law and that a correct interpretation compels a particular action, it shall:

"(A) Set aside or modify the order; or

"(B) Remand the case to the agency for further action under a correct interpretation of the provision of law.

"(b) The court shall remand the order to the agency if it finds the agency's exercise of discretion to be:

"(A) Outside the range of discretion delegated to the agency by law;

"(B) Inconsistent with an agency rule, an officially stated agency position, or a prior agency practice, if the inconsistency is not explained by the agency; or

"(C) Otherwise in violation of a constitutional or statutory provision.

"(c) The court shall set aside or remand the order if it finds that the order is not supported by substantial evidence in the record. Substantial evidence exists to support a finding of fact when the record, viewed as a whole, would permit a reasonable person to make that finding."

> The minute an attorney enters the examination, it becomes an advocate situation."

In rejecting the employer's assertion of obstruction by claimant, the referee stated:

> "I do not find much merit in the objections raised by the proposed examiners in this matter. * * * Claimant's attorney has agreed to do nothing more than observe. The examiners' suggestion that an attorney's mere presence would taint the examination is patently absurd and only bolsters concerns over examiner objectivity."

We take this to be a finding that the employer had not shown obstruction in fact, a finding that has adequate support in the record.

The decision of the Court of Appeals is reversed, and the decision of the Workers' Compensation Board is reinstated.

IN THE SUPREME COURT OF THE STATE OF OREGON

In the Matter of the Compensation of
Roland L. Dawkins, Claimant.

DAWKINS,
Petitioner on Review,

v.

PACIFIC MOTOR TRUCKING,
Respondent on Review.

(WCB No. 85-11265; CA A43907; SC S35407)

In Banc

On review from the Court of Appeals.*

Argued and submitted January 31, 1989.

Randy M. Elmer, Salem, filed the petition and argued the cause for petitioner on review. With him on the petition was Vick & Gutzler, Salem.

Thomas W. Sondag, Portland, filed the responses and argued the cause for respondent on review. With him on the responses was Spears, Lubersky, Bledsoe, Anderson, Young & Hilliard, Portland.

CARSON, J.

The decisions of the Workers' Compensation Board and the Court of Appeals are reversed. The case is remanded to the Board for proceedings consistent with this opinion.

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* Judicial review from order of Workers' Compensation Board. 91 Or App 562, 756 P2d 60, *reconsideration granted and former opinion adhered to,* 93 Or App 349, 762 P2d 329 (1988).

CARSON, J.

In this workers' compensation case, the issue is whether claimant is entitled to temporary total disability from the time of his aggravation claim until the determination that he was permanently and totally disabled. Relying in part upon *Cutright v. Weyerhaeuser,* 299 Or 290, 702 P2d 403 (1985), the hearings referee concluded that claimant is not entitled to temporary total disability. The Workers' Compensation Board affirmed, as did the Court of Appeals. *Dawkins v. Pacific Motor Trucking,* 91 Or App 562, 756 P2d 60, *reconsideration granted and former opinion adhered to,* 93 Or App 349, 762 P2d 329 (1988). We reverse the decisions below and remand the case to the Board.

Claimant is a 63-year-old former truck driver. Employer is a trucking company. In August 1982, claimant was involved in a work-related highway collision, resulting in serious injury, including an injury to his head. He underwent surgery to relieve a subdural hematoma. Claimant recovered from dizzy spells and headache, but continued to suffer from movement disorder, stamina loss, and cognitive dysfunction.

In February 1984, a determination order awarded claimant permanent partial disability of 176 degrees for 55 percent unscheduled disability resulting from the head injury (amounting to $17,600). Claimant and employer later agreed to an additional permanent partial disability award of 96 degrees for 30 percent unscheduled disability (amounting to an additional $9,600). The result was 85 percent total unscheduled permanent partial disability.

In July 1985, claimant's physician determined that his condition had deteriorated. The movement disorder had increased, while stamina and cognitive ability had decreased. Claimant filed an aggravation claim. Employer agreed to pay medical expenses but refused to pay temporary total disability because claimant had "retired."[1]

Subsequently, the Evaluation Division found claimant medically stationary and awarded him permanent total disability in lieu of permanent partial disability. It denied temporary total disability for the period between the filing of the aggravation claim (July 1985) and the award of permanent total disability (March 1986).

In June 1986, a hearing was held to determine whether claimant was entitled to temporary total disability. Claimant was drawing Social Security disability and a union disability pension. On the advice of his physician, claimant had neither worked, nor sought work, since August 1982, the date of the work-related injury. Claimant had entered a vocational rehabilitation program in 1984, but he was terminated from the program because of his physical and mental condition.

[1] In some instances, the measuring yardstick for denying compensation in this type of case has been characterized as whether the claimant has "voluntarily retired." *See Cutright v. Weyerhaeuser,* 299 Or 290, 293, 702 P2d 403 (1985); *State v. Commissioner,* 40 Ohio St 3d 44, 531 NE2d 678 (1988). We prefer to state the test as whether claimant has "withdrawn from the work force" rather than "retired." The latter word blurs rather than sharpens the inquiry.

It is undisputed that claimant's aggravation claim is related to his original compensable injury. Our inquiry focuses on whether claimant had withdrawn from the work force at the time of the aggravation of his prior work-related injury. If claimant had then withdrawn from the work force, the decision in *Cutright v. Weyerhaeuser, supra,* demands that he be denied temporary total disability.

This court, in *Cutright,* defined temporary total disability as "maintenance benefits intended to provide support and help replace lost income during the healing or recovery process." 299 Or at 302. In *Cutright,* each claimant sustained injury, was awarded permanent partial disability, and "voluntarily left" the work force. Each claimant's condition worsened and required surgery, and each applied for compensation for medical services and for temporary total disability. The employers paid medical expenses but refused to pay temporary total disability because claimants were no longer in the work force. 299 Or at 293. Relying on the claimants' voluntary withdrawal from the work force at the time of the aggravation of their prior work-related injuries, this court upheld the employers' refusal to pay temporary total disability. *Id.*

Cutright did not speak to a claimant who, although unable to work because of a prior compensable injury, yet may remain in the work force. In this case, the referee, the Board, and the Court of Appeals read *Cutright* to preclude temporary total disability for such a claimant. That was too broad a

reading of *Cutright.* The prior compensable injury may prevent the claimant from securing employment and, in extraordinary circumstances, may render futile any attempt to seek employment.

To receive temporary total disability upon aggravation of a work-related injury, the claimant must be in the work force at the time of the aggravation. *Cutright v. Weyerhaeuser, supra.* A claimant is deemed to be in the work force if:

a. The claimant is engaged in regular gainful employment; or
b. The claimant, although not employed at the time, is willing to work and is making reasonable efforts to obtain employment, *Cutright v. Weyerhaeuser, supra, see* ORS 656.206(3); or
c. The claimant is willing to work, although not employed at the time and not making reasonable efforts to obtain employment because of a work-related injury, where such efforts would be futile. *Cf. SAIF v. Stephen,* 308 Or 41, 47-48, 774 P2d 1103 (1989).

A claimant who is not employed, is not willing to be employed, or although willing to be employed is not making reasonable efforts to find employment (unless such efforts would be futile because of the work-related injury) has withdrawn from the work force. A claimant who, at the time of the aggravation of the work-related injury, has withdrawn from the work force is not entitled to temporary total disability.

Here, claimant's 85 percent permanent partial disability and worsened condition may excuse a failure to try to find employment and may avoid a finding that he had withdrawn from the work force if claimant otherwise was willing to work. We remand to the Board to find whether claimant had

withdrawn from the work force at the time of the aggravation of his prior work-related injury.

The decisions of the Workers' Compensation Board and the Court of Appeals are reversed. The case is remanded to the Board for proceedings consistent with this opinion.

IN THE SUPREME COURT OF THE STATE OF OREGON

In the Matter of the Compensation of Emil Kordon, Claimant.

KORDON,
Respondent on Review,

v.

MERCER INDUSTRIES et al,
Petitioners on Review.

(WCB 86-01089; CA A45185; SC S36033)

In Banc

On review from the Court of Appeals.*

Argued and submitted June 13, 1989.

John A. Reuling, Assistant Attorney General, Salem, argued the cause for petitioners on review. With him on the brief were Dave Frohnmayer, Attorney General, and Virginia Linder, Solicitor General, Salem.

James L. Edmunson, Eugene, argued the cause for respondent on review.

FADELEY, J.

The decision of the Court of Appeals is affirmed. The decision of the Workers' Compensation Board is reversed and the case is remanded to the Workers' Compensation Board to determine attorney fees.

* Appeal from the Workers' Compensation Board. 94 Or App 582, 766 P2d 1050 (1989).

FADELEY, J.

This is a workers' compensation case concerning attorney fees.

ORS 656.382(2) provides:

> "If a * * *, request for review, * * * is initiated by an * * * insurer, and the * * *, board * * * finds that the compensation awarded to a claimant should not be * * * reduced, the * * * insurer shall be required to pay the claimant * * * a reasonable attorney fee in an amount set by the * * * board * * *."

The issue in this case is whether the statute requires the Workers' Compensation Board to award attorney fees to a claimant who successfully defends against an insurer's response to a request for review seeking a reduction in the amount of the referee's disability award.

In 1981, Claimant Kordon suffered a back injury

while employed as an iron worker at Mercer Industries and filed a claim for permanent total disability. Kordon was awarded compensation for disability of 45 percent, equal to 144 degrees, for unscheduled permanent partial disability. After a hearing, a referee increased the award to 100 per cent unscheduled permanent partial disability equal to 320 degrees.

Claimant sought board review requesting permanent total disability. SAIF responded, "The referee's award of 100% unscheduled disability should be reduced." SAIF's response was entitled by it a "Cross-Appellant's Brief." The board affirmed the referee but denied claimant's request for attorney fees. Upon review, the Court of Appeals reversed the denial of attorney fees and remanded to the board to award fees. *Kordon v. Mercer Industries,* 94 Or App 582, 766 P2d 1050 (1989). We allowed review solely on the attorney fee issue. Both parties rely on ORS 656.382(2). We affirm.

After claimant sought board review, SAIF submitted a document entitled "Respondent's Brief/Cross-Appellant's Brief," which separately numbered and stated two "Issues." Regarding one issue, "Extent of Disability," SAIF affirmatively requested that the 320 degrees awarded by the referee "be reduced," specifically suggested a 100 degree reduction equal to $10,000, and argued:

"That portion of claimant's disability which is caused by

degenerative disc disease cannot be used to rate claimant's unscheduled disability because it is unrelated to the compensable back strain. Claimant's unscheduled disability award should be reduced to reflect that portion of claimant's disability caused by his failure to cooperate in his vocational rehabilitation."

In order to retain his 320 degree award equal to $32,000, claimant had to defend against these arguments before the board.

SAIF makes two arguments as to the proper characterization of its efforts to reduce the referee's compensation award. First, SAIF argues that "[t]here was no cross-request for review."[1] Second, SAIF argues that, if there was a cross-request for review to the board, ORS 686.382(2) does not authorize an award of attorney fees in the cross-request context.

In view of SAIF's specific request for a $10,000 reduction in the referee's award, it is difficult to credit SAIF's position that there was no cross-request for review. ORS 686.295(5) and board rules require a party to state in writing the issues and arguments the party asks the board to consider on review.[2] Apparently SAIF asks us to infer that it made no "request." Yet SAIF stated in writing both the reduction it requested and the arguments it urged for that result.

[1] The board's order denominates SAIF's request as "SAIF Corporation cross-requests review" and "employer's cross-appeal." At that time, OAR 438-11-015(3) required that "[a]ny party who has filed a cross-request for review * * * include its cross-appellant's opening statement as a part of its respondent's brief." SAIF did that.

[2] ORS 656.295(5) provides in part:

"The review by the board shall be based upon the record submitted to it * * * and such oral and written argument as it may receive. * * *"

At the time SAIF's brief was filed with the board, OAR 438-11-010, titled "*SCOPE OF BOARD REVIEW,*" provided in part:

"The Board will not ordinarily entertain oral argument. All issues and arguments should be reduced to writing * * *."

It would be semantic gamesmanship to argue that the issue tendered by SAIF's request to reduce compensation was the same as the issue claimant raised by requesting an increase in compensation. Although both issues generally concern the extent of compensation, the semantic game is foreclosed, in any event, by a portion of the analysis and holding in *Teel v. Weyerhauser,* 294 Or 588, 591, 660 P2d 155 (1983). In

that case we stated that the employer's cross-appeal to the Court of Appeals "forced claimant to defend his award," as a factual issue. 294 Or at 591. Also, we held that the employer's request for a reduced benefit "[raised] issues that would otherwise not be dealt with by the reviewing body." 294 Or at 590. Despite the employer's request, the Court of Appeals did not reduce claimant's award and this court held that the employer was deemed to have "initiated" an appeal on the compensability issue and was subject to an award of attorney fees under ORS 656.382(2).

Assuming, *arguendo,* that SAIF's request were not formally a cross-request, SAIF'S cross-appeal brief constitutes a request for review initiated by SAIF seeking reduced compensation. Attorney fees are due under the express words of ORS 656.382(2), which obligate the board to award such fees where an insurer initiates a request for a reduction in compensation but is unsuccessful.

SAIF's second argument — that a "cross-request" for review was intentionally omitted from ORS 656.382(2)'s mandate for reasonable attorney fees — lacks any supporting authority. It is true that the Workers' Compensation statutes do not employ the terminology of cross-request. ORS 656.295, ORS 656.313, and ORS 656.382 uniformly describe a request that the board change an award as a "request for review". No statutory distinction is made based on whether the request is brought by a claimant, an employer, or an insurer or whether or not it is the opening request to the reviewing authority or a request in a response of the opposing party. An employer or insurer, when responding to a claimant's "request for review," is permitted to seek other changes in the applicable order, but the statutes do not denominate any party's challenge to the referee's order by any name other than a request for review. *See* ORS 656.295. However, the words "cross-request" are found in the board's orders in this case. The term is also used by the board in an Oregon Administrative Rule, quoted in n 1 above, but is not used there in any context which supports SAIF's argument. We agree with the board that SAIF made a request and that denominating it a cross-request is a reasonable description of its functional purpose. A cross-request for review was made by the request for reduction in compensation which SAIF placed before the board.

SAIF argues that the legislature intended that no attorney fees be awarded on cross-requests for review because the 1983 legislature amended ORS 656.382(2) to add the provision that attorney fees were awardable on "cross-appeal to the Court of Appeals or petition for review to the Supreme Court" but did not include a provision to allow attorney fees for "cross-requests." From that omission, SAIF argues, this

court should infer a legislative intent to exclude fees in the cross-request context. When *Teel* was decided, ORS 656.832(2) provided for awards of attorney fees on "court appeal" but did not include the words "cross-appeal." *Teel* held that attorney fees must be awarded on a cross-appeal in the Court of Appeals under ORS 656.382(2) where that statute otherwise applied. One month before *Teel,* this court held in *Bracke v. Baza'r,* 294 Or 483, 490, 658 P2d 1158 (1983), that attorney fees were not allowable in the Supreme Court because the former version of ORS 656.382(2) did not expressly refer to petitions for review to the Supreme Court.

After *Bracke* and *Teel* were decided, the legislature amended ORS 656.382(2) to include "cross-appeal[s] to the Court of Appeals" and "petition[s] for review to the Supreme Court." Or Laws 1983, ch 568, § 1. The pre-existing statute, which provided for award of fees "[i]f a * * * request for review * * * is initiated by an employer or insurer" and is successfully defended against, was unchanged by the 1983 act.

The legislative history of the 1983 amendment includes no discussion of cross-requests for board review. We find SAIF's intention-by-omission argument unpersuasive. The legislature fixed what it believed was in need of repair, not what wasn't.[3] We conclude that "cross-request for review" is

encompassed by the words "request for review" in ORS 656.382(2). That statute requires SAIF to pay claimant a reasonable attorney fee in an amount to be determined by the board.[4]

The decision of the Court of Appeals is affirmed, and the case is remanded to the Workers' Compensation Board to determine attorney fees.

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[3] The 1983 amendments to ORS 656.382(2) were made by Senate Bill 589, introduced March 9, 1983. *Bracke v. Baza'r,* 294 Or 483, 490, 658 P2d 1158 (1983), was decided in February 1983. *Teel v. Weyerhauser,* 294 Or 588, 591, 660 P2d 155 (1983), reversing the Court of Appeals and allowing attorney fees on a cross-appeal, was decided later in March after Senate Bill 589 was introduced but before it was passed out of committee. Changes in the statute made by the bill added attorney fees in the context of cross-appeals in the Court of Appeals, consistent with *Teel,* and in the context of petitions for review in the Supreme Court, contrary to *Bracke.* A staff memorandum states that the bill was amended to "codify" the most recent ruling of the Oregon Supreme Court in the *Teel* case. The memorandum also states "[t]he original bill corrected only the situation in the *Bracke* case." Minutes, House Committee on Labor (June 29, 1983 — "Exhibit I"). No issue about requests versus cross-requests was placed before the legislature.

[4] OAR 438-15-070, titled *"ATTORNEY FEES WHEN INSURER OR SELF-INSURED EMPLOYER REQUESTS OR CROSS-REQUESTS REVIEW BY THE BOARD,"* provides:

> "If an insurer or self-insured employer requests or cross-requests review of the referee's order and the Board does not disallow or reduce the claimant's compensation, the board shall award a reasonable assessed fee."

This rule, which is consistent with our reading of ORS 656.382(2), became effective January 1, 1989. The present case was pending before the board in 1987.

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The following orders issued by the Workers' Compensation Board are not published in this volume because they were judged to be of no precedental value. Copies may be ordered from the Board using the numbers provided.

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Blair, Michael	89-0214M	4/27/89	Own Motion Order
Bock, Janice	89-0192M	4/17/89	Own Motion Order
Bogle, Bobby V.	89-0244M	8/25/89	Own Motion Order
Bosik, Robert W.	89-0327M	8/24/89	Own Motion Order
Bostock, Velora M.	89-0344M	6/29/89	Own Motion Order
Boucher, Marilyn F.	89-5904	9/13/89	Order of Dismissal
Boyd, Danny L.	87-0142M	3/89	Own Motion
Boyles, Kenneth	89-0069M	4/27/89	Own Motion Order
Braddock, Frank H.	89-0011M	2/89	Own Motion
Bradley, Zona	89-0524M	9/27/89	Own Motion Order
Brandon, Jack A., Jr.	89-0251M	5/17/89	Own Motion Order
Bratton, John R.	89-0291M	5/31/89	Own Motion Order
Breshears, Kathy B.	87-12775	6/29/89	Order on Review
Breshears, Kathy B.	87-12775	7/13/89	Amended Order on Review
Brezai, Joseph	89-0412M	8/22/89	Consent to Issuance of Order
Brickner, William T.	86-12777	4/17/89	Order on Reconsideration
Brickner, William T.	86-12777	3/89	Order on Review
Briley, Carroll	88-0799M	1/89	Own Motion
Brinson-Ayer, Barbara	89-0494M	9/7/89	Own Motion Order
Britt, Rocky S.	87-10677	8/24/89	Order on Review
Broadbent, Kenneth	89-0044M	2/89	Own Motion
Brooks, Glenda K.	89-0202M	4/28/89	Own Motion Order
Brown, Donie	89-0134M	3/89	Own Motion
Brown, Earl M.	86-00251	9/14/89	Order on Remand
Brown, Etta M.	86-08491	3/89	Order on Review
Brown, Gary D.	89-0199M	5/26/89	Order Postponing Action
Brown, Ovid D.	89-01586	9/14/89	Order of Dismissal
Brown, Patrick B.	88-0016M	3/89	Own Motion

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Name	WCB Number	Date	Type of Order
Brown, Rodney C.	87-08762 etc.	4/12/89	Order on Review
Brown, Wallace J.	88-22270	8/11/89	Order of Dismissal
Brundidge, Clen A.	86-09372	3/89	Order on Review
Buchanan, Clark W.	86-0412M	3/89	Own Motion
Buckle, Jerry V.	86-00040	2/23/89	Order on Review
Burboa, Joseph	89-0518M	9/29/89	Own Motion Order
Burch, Dwane M.	86-0585M	3/89	Own Motion
Burgess, Edward	89-0017M	3/89	Own Motion
Burnoski, Donald	88-0598M	8/25/89	Own Motion Order
Burns, Andrew J.	85-11851	9/7/89	Order of Dismissal
Burton, Arthur P.	88-19404	8/8/89	Order of Dismissal
Burton, James L.	88-0522M	8/23/89	Order Postponing Action
Bushbaum, Ronald J.	89-0345M	6/29/89	Own Motion Order
Byrne, William R.	89-0382M	7/13/89	Own Motion Order
Cahan, Shirley G.	89-0317M	8/8/89	Own Motion Order
Cahan, Shirley G.	89-0317M	8/22/89	Own Motion Order on Recon
Cahill-Martinez, S.	89-0206M	7/31/89	Own Motion Order
Campbell, Jess P.	87-0700M	4/7/89	Own Motion Order
Cantlo, Lorenzo D.	87-01495 etc.	8/17/89	Order on Review
Capron, Joseph G.	86-17129	8/17/89	Order on Review
Carlton, Ellen J.	87-19588	8/24/89	Order on Review
Carlton, Ellen J.	87-19588	9/6/89	Order on Reconsideration
Carlton, Richard J.	88-15046	9/14/89	Order of Dismissal
Carmichael, Karen A.	89-0517M	9/29/89	Own Motion Order
Carmien, James	88-0333M	3/89	Own Motion
Carpenter, Cheryl	87-00405	8/8/89	Order on Review
Carranza, Jose C.	88-03494	6/27/89	Order of Dismissal
Carrizales, Juan	89-0418M	8/9/89	Own Motion Order
Carroll, Elizabeth K.	86-10868	4/12/89	Order on Review
Carter, Dorothy	88-0476M	9/22/89	Own Motion Order
Carver, Valery D.	87-16146	8/17/89	Order on Review
Castro, Stewart	87-11003	3/89	Order on Review
Catto, Dale	89-0105M	3/89	Own Motion
Cecil, Cathy	89-0191M	4/20/89	Own Motion Order
Center, Gary D.	87-0536M	6/23/89	Own Motion Order of Dismissal
Chamberlain, Laurie	89-0511M	9/20/89	Own Motion Order
Chamness, Ronald E.	89-0298M	8/23/89	Own Motion Order
Chapman, Larry N.	87-12476	8/8/89	Order on Review
Chase, Sharon	88-0777M	3/89	Own Motion
Chavez, Rudolfo	86-10990	3/89	Order on Review
Christensen, Gary	89-0194M	8/11/89	Order Postponing Action
Christensen, Jesse D.	88-0081M	5/17/89	Supplemental Own Motion Order
Christensen, Susan J.	88-19346	5/26/89	Order of Dismissal
Christiansen, Daniel	89-0089M	2/89	Own Motion
Christopher, Ohman E.	87-0746M	2/89	Own Motion
Clancy, Patrick	87-0348M	3/89	Own Motion
Clark, Laura Lee	89-0434M	8/9/89	Own Motion Order
Clark, Ronald L.	87-06342	3/31/89	Order on Review
Clark, Thomas A.	87-19538	8/14/89	Order on Review
Clayton, Linda	89-0003M	3/89	Own Motion
Commella, Penny	89-0213M	4/27/89	Own Motion Order
Conmy, Gary E.	88-08008 etc.	8/11/89	Order of Dismissal
Cook, Colan R.	89-0473M	9/7/89	Own Motion Order
Cook, Maureen	89-0096M	3/89	Own Motion
Coonrod, Kenneth L.	89-0050M	2/89	Own Motion
Cooper, David	88-0684M	1/89	Own Motion

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Name	WCB Number	Date	Type of Order
Cooper, Helen M.	86-04023	8/15/89	Order on Review
Corbin, Dave	88-0410M	5/30/89	Own Motion Order on Recon
Cornell, Thomas D.	88-0452M	5/30/89	Own Motion Order
Cortez, Eric G.	87-03293	3/89	Order on Review
Couch, Billie D.	87-0322M	3/89	Own Motion
Coulter, Roberta E.	89-0366M	7/13/89	Own Motion Order
Cox, Lewis J.	86-00938 etc.	9/21/89	Order on Review
Crabtree, Ruth E.	87-14601	4/27/89	Order on Review
Crain, Carl W.	86-05256	4/17/89	Order on Reconsideration
Crenshaw, Carl	88-0816M	1/89	Own Motion
Cross, Josephine	87-06195	7/19/89	Order on Review
Cruzan, Herbert D.	88-0658M	3/89	Own Motion
Cummins, Richard	89-0273M	5/26/89	Own Motion Order
Cunial, Robert M.	87-16835	4/12/89	Order on Review
Curin, James A.	88-12206	6/8/89	Order of Dismissal
Cutler, Gary L.	89-0039M	2/89	Own Motion
Dahlke, Neil E.	86-11045	7/21/89	Order on Review
Daley, Warren	89-0135M	3/89	Own Motion
Dalgliesh, Kenneth G.	87-17930	8/31/89	Order on Review
Dalton, Robert W.	88-0085M	1/89	Own Motion
David Hernandez, Isabel	88-0071M	1/89	Own Motion
David, (n/a)	87-06862	2/89	Order on Review
Davidson, Richard	85-0612M	1/89	Own Motion
Davis, Johnny A.	89-01213	8/15/89	Order of Dismissal
Davis, Marvin R.	89-0337M	6/29/89	Own Motion Order
Dawson, Dennis L.	88-0812M	2/89	Own Motion
Deal, Joann M.	87-0355M	3/89	Own Motion
Dearmond, Gayford	87-0475M	3/89	Own Motion
Dearmore, Melodee A.	88-17533	6/21/89	Order of Dismissal
Degarlais, Kevin P.	86-08619 etc.	8/18/89	Order on Review
Degarlais, Kevin P.	86-08619 etc.	8/31/89	Order on Reconsideration
Deguchi, Karen A.	89-0474M	9/7/89	Own Motion Order
Delacruz, Reynaldo	89-0247M	5/17/89	Own Motion Order
Delano, Joyce G.	88-0638M	7/21/89	Own Motion Determination
Delano, Joyce G.	88-0638M	8/21/89	Own Motion Order
Delany, Debra J.	86-11889	6/23/89	Order on Review
Denny, Carol	88-0766M	3/89	Own Motion
Derby, Richard	89-0051M	2/89	Own Motion
Derby, Robert E.	87-15685	8/14/89	Order on Review
Devaney, Frederick J.	89-07553	8/8/89	Order of Dismissal
Diaz, Jesus	87-18338	8/24/89	Order on Review
Diebel, Daniel	88-0544M	3/89	Own Motion
Diemer, Anita	89-0101M	3/89	Own Motion
Diemer, Anita	89-0101M	5/17/89	Own Motion Order of Dismissal
Dilley, Patrick	89-0033M	2/89	Own Motion
Dilworth, Jerry D.	86-16967	2/9/89	Order on Review
Dimmick, Dennis A.	89-0452M	9/6/89	Own Motion Order
Dixon, Marlene	88-0828M	1/89	Own Motion
Dobbs, Michael	89-0187M	4/17/89	Own Motion Order
Dobyns, Kathleen M.	87-03976	3/89	Order on Review
Dockstader, Virginia L.	89-0466M	9/26/89	Own Motion Order
Dooley, Stephen C.	84-0245M	6/19/89	Own Motion Order of Dismissal
Doran, Ron A.	87-09785	3/89	Order on Review
Douroux, Lawrence J.	89-0531M	9/27/89f	Denial of Consent
Dowers, Denton N.	87-05480	5/9/89	Order on Review
Downey, John L.	86-17785	3/89	Order on Review

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Name	WCB Number	Date	Type of Order
Drage, Norman H.	89-04924	8/15/89	Interim Order of Dismissal
Drago, Jeffery L.	89-0234M	5/17/89	Own Motion Order
Drew, Dorothy J.	89-0373M	7/13/89	Own Motion Order
Dupont, Jill	89-0299M	7/28/89	Own Motion Order
Dupree, Derland A.	85-10471	3/89	Order on Review
Duran, Rudolfo	87-16152	8/18/89	Order on Review
Dvorak, Diane	89-0284M	5/31/89	Own Motion Order
Dyton, Norman G.	86-14661	5/11/89	Order Denying Abatement
Eagleton, Beulah M.	89-0002M	1/89	Own Motion
Eaton, Eleanor A.	87-0728M	5/31/89	Own Motion Order
Eccleston, Frank E.	87-05705	7/13/89	Order of Dismissal
Edens, Glen L.	84-07667 etc.	3/14/89	Order Denying Request
Edwards, Michael	88-0033M	8/9/89	Own Motion Order
Efimoff, Nikolay	87-07192	5/12/89	Order on Review
Eichelberg, Timothy J.	89-0483M	9/7/89	Own Motion Order
Elder, Monty R.	89-0432M	9/22/89	Own Motion Order/Recon
Elder, Monty R.	89-0432M	8/22/89	Own Motion Order
Elizondo, Richard R.	89-0413M	8/9/89	Own Motion Order
Eller, Shirley B.	86-16577	7/13/89	Order on Review
Ellis, Gary	89-0025M	1/89	Own Motion
Ellis-Phillips, Jodey	88-0796M	1/89	Own Motion
Ellison, Jeanette M.	89-0389M	8/23/89	Own Motion Order
Ellison, Jeanette M.	89-0180M	4/17/89	Order Postponing Action
Ells, Marion L.	86-0454M	7/5/89	Own Motion Determination
Ells, Marion L.	86-0454M	7/28/89	Own Motion Order of Abatement
Elston, David	88-0045M	8/8/89	Own Motion Order
Emerson, Charles	89-0381M	8/23/89	Own Motion Order
Emerson, Phillip	89-0223M	4/28/89	Own Motion Order
Emmert, Marvin E.	89-0128M	3/89	Own Motion
Engleman, Gregory E.	88-13625 etc.	5/3/89	Order of Dismissal
English, James C.	88-0641M	2/89	Own Motion
Epps, William A.	89-0415M	7/21/89	Own Motion Order
Erickson, Dennis R.	88-0161M	5/30/89	Own Motion Order
Erickson, Lillian	87-0329M	3/89	Own Motion
Erler, James	89-0488M	9/18/89	Own Motion Order
Evatt, Raymond	88-11930	7/27/89	Order of Dismissal
Ewing, Michael R.	87-03058	7/18/89	Order on Review
Eyman, Ronald L.	88-0114M	3/89	Own Motion
Farkas, Marcy S.	87-18794	9/26/89	Order on Review
Farmer, Charles A.	88-0243M	4/5/89	Own Motion Determination
Farnes, Marilyn A.	89-0406M	7/27/89	Order Postponing Action
Felton, Richard	89-0314M	6/15/89	Own Motion Order
Fenison, Richard L.	87-10955	6/27/89	Order on Review
Fenter, Roger G.	89-0095M	5/30/89	Own Motion Determination
Ferber, Gwynn	86-0417M	1/89	Own Motion
Ferland, Pierre R.	89-01238 etc.	9/21/89	Interim Order of Dismissal
Fincher, Delores J.	89-0131M	3/89	Own Motion
Fischer, Richard	89-0271M	5/31/89	Own Motion Order
Fisher, Delmar E.	86-03939	3/28/89	Order on Review
Fite, Lige	89-0237M	5/31/89	Own Motion on Recon
Fite, Lige	89-0237M	5/12/89	Own Motion Order
Fitzgerald, John L.	89-0240M	5/12/89	Own Motion Order
Flannery, Leonard K.	89-0155M	3/89	Own Motion
Forrester, Harry	88-0814M	3/89	Own Motion
Foss, Jerry H.	89-0585M	8/11/89	Order Postponing Action
Foss, Jerry H.	89-0037M	8/22/89	Amended Order

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Name	WCB Number	Date	Type of Order
Foster, Agnes K.	89-0391M	9/13/89	Own Motion Order
Fourier, Shirley L.	86-0279M	4/17/89	Own Motion Order
Fouts, Leonard C.	88-0775M	3/89	Own Motion
Fouts, Leonard C.	88-0775M	5/17/89	Own Motion Order of Dismissal
Fowler, Leroy R.	89-0016M	1/89	Own Motion
Fowlkes, Richard E.	87-01920	5/17/89	Order on Review
Fox, Gary	89-0359M	6/19/89	Own Motion Order
Fox, Larry W.	88-20145	6/21/89	Order of Dismissal
Francoeur, Idalee E.	86-09705	3/8/89	Order on Review
Franks, Lou	89-0212M	4/27/89	Own Motion Order
Fraser, Brian P.	89-0015M	1/89	Own Motion
Frasieur, Wayne	89-0290M	5/31/89	Own Motion Order
Frazier, Dennis W.	89-0370M	7/7/89	Own Motion Order
Freed, John P.	88-0463M	3/89	Own Motion
Fulfer, Bobby L.	86-16503	8/8/89	Order on Review
Fulfer, Bobby L.	86-16503	9/1/89	Order Denying Motion
Fuller, Virginia	89-0111M	3/89	Own Motion
Fulop, David	89-05461	8/15/89	Interim Order of Dismissal
Gandy, Kenneth	89-0079M	3/89	Own Motion
Garcia, Debra J.	86-07131	4/12/89	Order on Review
Garcia, Jesus	TP-88030	6/13/89	Amended Third Party Order
Garoutte, Howard	89-0346M	8/11/89	Own Motion Order
Garrison, Ken	87-09021	2/89	Order on Review
Garza, Anita	89-0224M	8/23/89	Own Motion Order
Gastaldi, Christopher	89-0163M	4/5/89	Own Motion Order
Gates, Mary L.	89-0323M	6/12/89	Own Motion Order
Gautier, Roberta B.	86-17739	5/17/89	Order on Review
Gerdes, Angelia F.	89-02764	8/31/89	Order of Dismissal
Germeroth, Raymond R.	87-17956	9/19/89	Order of Dismissal
Getty, Delbert	89-0219M	5/17/89	Own Motion Order
Gianella, Lorraine C.	88-07713	5/31/89	Order of Dismissal
Gibbs, Daniel	87-0134M	5/17/89	Own Motion Determination
Gibbs, Frank L.	86-0002M	3/89	Own Motion
Gill, William R.	86-10065	3/89	Order on Review
Girtman, Eldon L.	86-16358	4/12/89	Order on Review
Gitelson, Allan	89-0205M	6/19/89	Own Motion Order
Giumelli, Edwin W.	88-18033	5/23/89	Order of Dismissal
Glenn, Lester	88-0561M	2/89	Own Motion
Good, David	88-0408M	1/89	Own Motion
Goodman, Shirley J.	87-10531	5/12/89	Order on Review
Gorrell, Teresa M.	88-13453 etc.	6/21/89	Order of Dismissal
Goulet, Anita D.	89-01254 etc.	8/15/89	Order of Dismissal
Graham, Anthony R.	86-18026	6/8/89	Order on Review
Graham, Lisa L.	87-07478	1/89	Order on Review
Graham, Robert	88-0783M	3/89	Own Motion
Graham, Robert J.	88-0783M	4/17/89	Order Approving Request
Green, Clarence	89-00830	4/21/89	Order of Dismissal
Green, Marvin	85-00521	4/12/89	Order on Review
Green, Valori J.	88-16092 etc.	9/6/89	Order of Dismissal
Greene, Glenda J.	87-15696	6/27/89	Order on Review
Greene, Glenda J.	87-15696	7/18/89	Amended Order on Review
Greene, Michael A.	87-12431 etc.	8/31/89	Order on Review
Gregg (Freeman), Laurie	87-0180M	3/89	Own Motion
Gregory, Donald T.	87-18908 etc.	5/4/89	Order on Review
Greve, Everett	89-0164M	4/17/89	Own Motion Order
Griffith, Thomas W.	89-0454M	8/22/89	Denial of Consent

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Name	WCB Number	Date	Type of Order
Griffith, Vernon	89-0139M	3/89	Own Motion
Grimes, Rebecca J.	87-12892	1/89	Order on Review
Grimes, Scott L.	88-03037	7/19/89	Order on Review
Grimm, James	89-0272M	5/26/89	Own Motion Order
Grimshaw, Edith	88-0701M	5/23/89	Own Motion Order
Grosdidier, Herbert L.	87-02216	4/18/89	Order on Review
Grosz, Bradley	89-0444M	8/18/89	Own Motion Order
Guerrero, Anthony R.	89-0441M	8/23/89	Own Motion Order
Gullatt, Reta	88-0370M	6/6/89	Own Motion Order
Gunderson, William F.	89-01631	8/8/89	Order of Dismissal
Gustafson, Jacquetta	89-0431M	8/23/89	Own Motion Order
Gutierrez, Antonio	89-0178M	7/7/89	Own Motion Order
Guttierrez, Maria T.	86-16076	6/29/89	Order of Dismissal
Gymkowski, Joseph J.	89-0049M	8/23/89	Own Motion Order
Hainey, Sarah	89-0316M	6/12/89	Order Postponing Action
Hall, Patricia N.	87-09563	1/89	Order on Review
Halliwell, Kenneth R.	89-0332M	6/23/89	Own Motion Order
Hamilton, Harold	88-0806M	1/89	Own Motion
Hamilton, John G.	89-0428M	9/18/89	Order Postponing Action
Hammond, Duane E.	89-0052M	5/23/89	Own Motion Order
Hannah, Mark	87-03354	8/17/89	Order on Review
Hanson, Craig R.	89-0394M	7/20/89	Own Motion Order
Hanson, Kathleen M.	89-0311M	6/15/89	Own Motion Order
Hardy, Thomas C.	89-0380M	9/26/89	Own Motion Order
Hargand, Charles H.	87-00715 etc.	3/89	Order on Review
Hargens, Clyde M.	89-0521M	9/27/89	Own Motion Order
Hargis, Carolyn A.	89-0276M	8/24/89	Own Motion Order
Hargis, Kimberly D.	88-13162	8/7/89	Order of Dismissal
Haron, Louis	83-0348M etc.	7/27/89	Own Motion Order
Harper, Betty L.	87-0763M	2/89	Own Motion
Harris, Eddie	87-01168	8/18/89	Order on Review
Harris, Rex A.	87-04927	8/17/89	Order on Review
Harrison, Thomas E.	87-18113 etc.	8/23/89	Order on Review
Hart, Michael W.	87-06547	4/18/89	Order on Review
Hartle, James	89-0260M	5/26/89	Own Motion Order
Hatfield, Wilma	87-0573M	2/89	Own Motion
Hawkins, Floyd	83-0382M	3/89	Own Motion
Hayes, Bobby J.	88-17438	5/23/89	Order of Dismissal
Hayes, Dorothy J.	89-0257M	5/17/89	Own Motion Order
Hayhurst, Landy J.	86-10957	3/8/89	Order on Review
Healy, Gene	89-0162M	4/5/89	Own Motion Order
Heater, William E.	89-0347M	6/29/89	Own Motion Order
Hein, Thomas C., Sr.	89-0320M	8/9/89	Own Motion Order
Helm, Jacob M.	86-0112M	4/7/89	Own Motion Determination
Hembree, Donald E.	89-0014M	1/89	Own Motion
Hendershott, Kenneth A.	87-17525	6/6/89	Order on Review
Henry, John	88-0823M	2/89	Own Motion
Hernandez, Eustaquio A.	87-00505	4/7/89	Order on Review
Herndon, Melva J.	86-11992	7/27/89	Order on Review
Herrera, Lucianno B.	89-0460M	8/22/89	Own Motion Order
Herrera, Raul	88-0774M	6/30/89	Own Motion Order
Hershey, Thomas E., Sr.	89-0062M	2/89	Own Motion
Hewit, Kenneth J.	88-0744M	5/30/89	Own Motion Order
Hiatt, Sally A.	89-0338M	7/21/89	Own Motion Order
Hickman, Darlene	88-0690M	5/31/89	Own Motion Order of Dismissal
Hicks, Mitchell	88-0705M	1/89	Own Motion

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Name	WCB Number	Date	Type of Order
Higgins, James	88-0752M	1/89	Own Motion
Hilderbrand, James R.	85-15943	6/27/89	Order on Review
Hileman, Leroy V.	89-0186M	4/17/89	Own Motion Order
Hill, Ronald	87-07745	3/89	Order on Review
Hinkle, Curtis R.	89-0374M	7/7/89	Own Motion Order
Hinson, Gayle	88-0730M	1/89	Own Motion
Hockett, Verna	89-0353M	8/23/89	Own Motion Order
Hodgert, Thomas K.	87-02097 etc.	6/26/89	Order of Dismissal
Hodges, Charles V., Jr.	88-0785M	1/89	Own Motion
Hoffman, Colleen M.	89-0339M	6/29/89	Own Motion Order
Hofmann, Kevin	89-0286M	5/23/89	Consent to Issuance
Hofmann, Kevin	89-0286M	9/7/89	Own Motion Order
Hoiting, Lawrence	88-0788M	4/17/89	Own Motion Order
Holifield, Jerry R.	86-16731	5/16/89	Order of Dismissal
Holifield, Kelly R.	87-14557	4/7/89	Order on Review
Holliday, William E.	89-0255M	5/17/89	Own Motion Order
Holmes, Christine R.	89-0312M	8/11/89	Own Motion Order
Holst, Albert S.	87-0530M	1/89	Own Motion
Holsti, Hugo L.	88-0365M	6/29/89	Own Motion Order
Holub, Faye	89-0482M	9/26/89	Own Motion Order
Hookland, Richard	89-0073M	2/89	Own Motion
Horton, Jennifer E.	87-07738	8/8/89	Order on Review
Hostler, Frank	89-0481M	9/7/89	Own Motion Order
Houk, Loran	88-0479M	9/6/89	Attorney Withdrawal
Howard, James E.	87-0747M	5/31/89	Own Motion on Recon
Howard, Richard	89-0074M	2/89	Own Motion
Howard, Ronald H.	87-06996	6/12/89	Order on Review
Howell, Chris T.	87-18819	9/29/89	Order on Review
Howell, Darla J.	89-0026M	4/14/89	Own Motion Order
Howell, Donald	88-0357M	3/89	Own Motion
Howell, Steven	86-11800	4/12/89	Order on Review
Howze, Betty J.	88-13069 etc.	9/20/89	Order of Dismissal
Hubbard, Jeannie S.	87-11297 etc.	8/31/89	Order on Review
Hubert, John J.	87-06575	8/15/89	Order on Review
Hughes, Huey H.	87-17775	9/26/89	Order on Review
Humphrey, Fay	89-01566M	4/5/89	Own Motion Order
Hunt, Clifford E.	89-0130M	3/89	Own Motion
Huntsucker, Clifford	89-0102M	3/89	Own Motion
Hurd, Clifford	89-0471M	8/30/89	Own Motion Order
Hyde, James	84-0419M	3/89	Own Motion
Hyde, Perry A.	89-0340M	8/23/89	Own Motion Order
Irwin, Robert	89-0008M	2/89	Own Motion
Ishaque, Sedayan	87-14238	9/13/89	2nd Order on Reconsideration
Ishaque, Sedayan	87-14238	8/14/89	Order on Recon
Ishaque, Sedayan	87-14238	7/27/89	Order on Review
Ivanoff, George S.	87-0673M	5/23/89	Amended Own Motion
Ivie, Edward H.	87-12119	9/28/89	Order on Review
Jackson, Donald	89-0036M	3/89	Own Motion
Jackson, Donald C.	89-0036M	5/31/89	Own Motion Order
Jackson, Robert D.	89-0510M	9/22/89	Own Motion Order
Jackson, Robert D.	87-0185M	9/18/89	Own Motion Order
Jacobs, Larry	89-0204M	4/27/89	Own Motion Order
Jacobson, Bert N.	85-0648M	3/89	Own Motion
Jaeger, Jon D.	87-04158 etc.	2/23/89	Order on Review
James, Amanda M.	87-04606	7/7/89	Order on Reconsideration
James, Amanda M.	87-04606	6/13/89	Order on Review

Name	WCB Number	Date	Type of Order
James, Gary J.	86-04564	4/20/89	Order Denying Reconsideration
James, Leslie M.	89-0516M	9/27/89	Own Motion Order
James, Pamela D.	89-0322M	7/31/89	Own Motion Order
James, Sharon L.	87-03748	4/18/89	Order on Review
Jeremiah, Gary T.	87-11882 etc.	8/24/89	Order on Review
Jochem, Nellie J.	86-15609	8/23/89	Order on Review
Jochem, Nellie J.	86-15609	9/22/89	Order on Recon
Johnson, Barbara L.	87-16924	6/13/89	Order of Dismissal
Johnson, Betty Lue	88-0311M	3/89	Own Motion
Johnson, Cordy	88-0736M	5/26/89	Own Motion Determination
Johnson, Edward	89-0158M	4/5/89	Own Motion Order
Johnson, Harry	88-0822M	2/89	Own Motion
Johnson, Leon	89-0280M	5/17/89	Own Motion Order
Johnson, Mark A.	87-02654	2/89	Order on Review
Johnson, Matthew W.	89-0383M	7/13/89	Own Motion Order
Johnson, Robert H.	87-06101 etc.	7/18/89	Order of Abatement
Johnson, Robert H.	87-06101 etc.	8/14/89	2nd Order on Recon
Johnson, Robert H.	87-06101 etc.	5/4/89	Order on Review
Johnson, Robert H.	87-06101 etc.	5/26/89	Order of Abatement
Johnson, Robert H.	87-06101 etc.	6/19/89	Order on Reconsideration
Johnson, Robert W.	87-13077	2/3/89	Order on Reconsideration
Johnson, Robert W.	87-13077	2/22/89	2nd Order on Reconsideration
Johnson, Roosevelt	89-0080M	7/13/89	Order Postponing Action
Johnson, William	89-0420M	8/23/89	Own Motion Order
Johnson, William D.	87-08530 etc.	3/89	Order on Review
Johnson-Schotz, Anita	86-10972	5/4/89	Order on Review
Johnson-Schotz, Anita	86-10972	5/23/89	Amended Order on Review
Johnston, Sheila	89-0072M	2/89	Own Motion
Jolley, Loretta A.	87-04307	5/17/89	Order on Review
Jones, Beverly J.	89-0161M	4/27/89	Own Motion Order
Jones, Charles	89-0395M	8/11/89	Own Motion Order
Jones, Henry L.	86-05795 etc.	9/18/89	Order of Dismissal
Jones, Margaret	89-0032M	1/89	Own Motion
Joseph, Elaine	87-0740M	1/89	Own Motion
Josi, Robert E.	89-0166M	4/5/89	Own Motion Order
Joye, Michael J.	87-16781	8/18/89	Order on Review
Judd, Carl F.	88-0809M	6/16/89	Order Postponing Action
Judkins, David	88-0395M	3/89	Own Motion
Juker, Melvin E.	87-00983 etc.	5/17/89	Order on Review
Jungling, Lynn	89-0333M	6/12/89	Own Motion Order
Justen, Terry	88-0207M	3/89	Own Motion
Kacherwski, Edward	89-0066M	8/23/89	Own Motion Order
Kaeo, Cornel D.	87-06274	2/16/89	Order on Review
Kaeo, Cornel D.	87-06274	3/20/89	Order on Reconsideration
Kaiser, Lillian	89-0375M	9/20/89	Own Motion Order
Karam, Charles	89-0421M	8/9/89	Own Motion Order
Karstetter, Donald B.	89-0451M	9/7/89	Own Motion Order
Kartak, Michael	88-0656M	3/89	Own Motion
Keen, Gwendolyn	88-0498M	5/22/89	Own Motion Order
Keen, Theodore W.	87-14914	8/24/89	Order on Review
Keen, Theodore W.	87-14914	9/13/89	Order on Reconsideration
Keimig, Jeffery P.	86-14810	8/25/89	Order of Dismissal
Kemhus, Evelyn E.	86-15806	2/23/89	Order on Review
Kennedy, Delaine	89-0021M	5/31/89	Own Motion Order
Kennedy, Delaine	89-0021M	6/27/89	Own Motion Order
Kennedy, Dewey	89-0188M	4/17/89	Own Motion Order

Name	WCB Number	Date	Type of Order
Kennedy, Leo	88-0246M	7/18/89	Own Motion Order
Kennedy, Richard	89-0113M	3/89	Own Motion
Kern, Calvin, Jr.	89-0243M	5/9/89	Own Motion Order
Keslar, Bruce D.	87-13993	9/26/89	Order on Review
Kessinger, Beverly A.	87-08908	9/26/89	Order on Review
Kim, Hoe Sun	87-02246	8/10/89	Amended Order on Review
Kim, Hoe Sun	87-02246	7/18/89	Order on Review
King, James M.	89-0082M	7/27/89	Own Motion Order
King, Janice M.	89-0136M	3/89	Own Motion
King, Judith	89-0068M	3/89	Own Motion
King, Kathy M.	89-0402M	7/20/89	Own Motion Order
King, Walter F.	89-0117M	3/89	Own Motion
King, William R.	89-0012M	1/89	Own Motion
Kingsland, Alfred	89-0099M	3/89	Own Motion
Kinney, Carla J.	88-00532	9/26/89	Order of Dismissal
Kintz, Keith J.	89-0196M	4/17/89	Own Motion Order
Kirk, Vona	87-16904	6/19/89	Order on Review
Kirkpatrick, Charles D.	87-06660	8/31/89	Order on Review
Kissee, Ted R.	87-17975 etc.	6/13/89	Order on Review
Kissee, Ted R.	87-0519M	6/13/89	Own Motion Order
Kitchin, Ronald	88-0810M	3/89	Own Motion
Kloss, John C.	89-0348M	8/23/89	Own Motion Order
Knapp, Gerald	88-0672M	2/89	Own Motion
Knaub, Gary A.	89-0296M	5/31/89	Consent to Issuance Order
Knaub, Gary A.	89-0296M	5/31/89	Own Motion Order
Knodel, Carol	89-0065M	2/89	Own Motion
Kosel, Lucie Mae	88-0532M	1/89	Own Motion
Koss, Kathleen A.	87-03299 etc.	7/7/89	Order on Review
Krening, Jack E.	89-0083M	3/89	Own Motion
Krueger, Harriett L.	87-02876	1/5/89	Order on Review
Krussell, Robert L.	87-16931	2,3/89	Order on Review
Lacy, George L.	86-09432	1/89	Order on Review
LaGrow, Sharon A.	87-08943	9/21/89	Amended Order on Review
LaGrow, Sharon A.	87-08943	8/31/89	Order on Review
Lahodny, Beverly	89-0301M	6/15/89	Own Motion Order
Lakey, Conrad	89-0055M	2/89	Own Motion
Lammon, Caleb	87-00911	6/15/89	Order on Review
Landeros, Jose L.	87-05498	6/13/89	Order on Review
Landon, Cal E.	88-14942	8/11/89	Order of Dismissal
Lang, Terry	89-0306M	6/12/89	Own Motion Order
Largent, Mark S.	(Employer)	9/1/89	Order Denying Motion
Largent, Mark S. (emp.)	86-16503	8/8/89	Order on Review
Larsen, Teri L.	88-0780M	5/3/89	Own Motion on Recon
Larsen, Teri L.	88-0780M	2,3/89	Own Motion
Larson, Vincent C., Jr.	87-04090	7/27/89	Order of Dismissal
Laur, Harold	89-0172M	5/31/89	Own Motion Order
Lausche, Eugene	89-0168M	4/17/89	Own Motion Order
LaVert, Bertha Barber	89-0369M	6/23/89	Denial of Consent
Leafdahl, Duane C.	89-0292M	8/23/89	Own Motion Order
Leaton, Daniel	88-0583M	5/31/89	Own Motion Order
Lee, Larry J.	86-17527	7/5/89	Order of Dismissal
Lee, Robert E.	89-0094M	3/89	Own Motion
Lehmeyer, Barbara J.	87-17444	8/31/89	Order on Review
Lemons, Kim	89-0120M	3/89	Own Motion
Lenhart, Guy A.	88-0468M	9/27/89	Own Motion Order
Lenning, Mark L.	88-05282	5/30/89	Order of Dismissal

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Name	WCB Number	Date	Type of Order
Leslie, Paul E.	87-0715M	2/89	Own Motion
Lewis, William C.	89-0501M	9/27/89	Own Motion Order
Liday, Minor G.	88-0138M	4/5/89	Own Motion Order
Linday, Jeff	89-0177M	4/17/89	
Lindsay, William	89-0328M	6/26/89	Own Motion Order
Lingard-Miller, June L.	87-13236	9/19/89	Order of Dismissal
Link, Terry L.	86-01751	9/14/89	Order on Remand
Littleton, Robert S.	85-0247M	9/6/89	Own Motion Order
Liverman, Jack	88-0490M	3/89	Own Motion
Lloyd, Audley, Jr.	89-0319M	6/26/89	Own Motion Order
Lloyd, John H.	89-0084M	7/13/89	Own Motion Order
Lockard, Earnestine	86-0076M	4/27/89	Own Motion Order of Dismissal
Lodeski, Carlene	89-0198M	4/19/89	Order Postponing Action
Loew, Frank F.	89-0419M	8/11/89	Own Motion Order
Loftus-Stewart, Joan M.	86-09953	7/27/89	Order on Review
Loftus-Stewart, Joan M.	86-09953	8/10/89	Corrected Order on Review
Logan, Richard	85-0591M	3/89	Own Motion
Lombardi, Linda L.	86-11315	2/89	Order on Review
Lotfi, Fred	89-0023M	3/89	Own Motion
Loughridge, Karen J.	87-17232	9/26/89	Order on Review
Love, William	89-0054M	2/89	Own Motion
Lucas, Kelly R.	86-07032 etc.	8/31/89	Order on Review
Lunsford, Herman	89-0263M	5/17/89	Own Motion Order
Lutz, Bryan	89-0360M	6/29/89	Own Motion Order
Lyness, George V.	89-01360	8/8/89	Order of Dismissal
Lytsell, Leneita E.	87-04410	8/18/89	Order on Review
Lytton, Kenneth L.	88-0797M	5/17/89	Own Motion Order
Mack, Ronald G.	87-13647	6/13/89	Order on Review
MacKenzie, Eric W.	87-18256	4/18/89	Interim Order of Remand
Madsen, Melvin	89-0256M	5/17/89	Own Motion Order
Magnuson, Wesley	89-0309M	5/31/89	Consent to Issuance Order
Magoulas, Jim F.	89-0027M	2/89	Own Motion
Malar, Shirley E.	89-0315M	6/12/89	Own Motion Order
Malone, Ben D.	88-20728	9/13/89	Order of Dismissal
Malpass, John W.	89-0330M	8/23/89	Own Motion Order
Mangun-Wolverton, B.	88-0147M	1/89	Own Motion
Mapes, Robert L.	87-04038	1/89	Order on Review
Mapes-Flores, Michele	89-0401M	7/21/89	Own Motion Order
Marchuk, James M.	88-0673M	1/89	Own Motion
Marks, Norman	89-0254M	5/30/89	Own Motion Order
Marr, Richard J.	85-09698	8/17/89	Order on Review
Marsh, Jackquline	89-0022M	2/89	Own Motion
Marsh, Leora F.	88-0517M	8/8/89	Own Motion Order
Marshall, Arlene	86-06142	3/14/89	Order Denying Request
Martin, David	84-0207M	1/89	Own Motion
Martin, Elson	88-0152M	1/89	Own Motion
Martinez, Roberto C.	88-02787	5/17/89	Order of Dismissal
Martinez, Roberto C.	88-02787	5/23/89	Amended Order of Dismissal
Marugg, Darrell M.	87-12998	4/12/89	Order on Review
Marziano, Mario	88-12262	8/10/89	Amended Order of Dismissal
Marziano, Mario	88-12262	7/17/89	Order of Dismissal
Marziano, Mario	88-12262	6/13/89	Order Withdrawing Dismissal
Marziano, Mario	88-12262	5/31/89	Order of Dismissal
Masterfield, Charles E.	87-01152	9/7/89	Amended Order on Review
Masterfield, Charles E.	87-01152	8/31/89	Order on Review
Maugh, Floyd	89-0137M	3/89	Own Motion

Name	WCB Number	Date	Type of Order
Maul, Christopher	89-0331M	6/14/89	Own Motion Order
Maupin, Eddy	87-0122M	8/8/89	Own Motion Order
Maupin, Eddy V.	87-0122M	1/89	Own Motion
May, Ronald L.	88-0589M	1/89	Own Motion
May, Ronald L.	88-21868 etc.	7/13/89	Order of Dismissal
Mayhew, Mark A.	89-00311	6/27/89	Order of Dismissal
McArthur, William L.	86-05236 etc.	3/2/89	Order on Review
McCullough, A.G.	87-08992	6/8/89	Order of Dismissal
McCullough, A.G.	87-08992	7/7/89	Order on Reconsideration
McDaniel, Ronald L.	89-0453M	8/22/89	Own Motion Order
McDaniel, Ronald L.	89-0171M	4/19/89	Own Motion Order
McDonald, William H.	86-10876	8/8/89	Order on Review
McDougald, Gene C.	89-0190M	4/17/89	Own Motion Order
McDougall, Leslie A.	87-0669M	9/26/89	Own Motion Order/Abatement
McFall, Dora	88-0453M	1/89	Own Motion
McGarvey, Dwight E.	86-08263 etc.	9/1/89	Order on Review
McGuire, Larry J.	87-18198	7/31/89	Order of Dismissal
McKee, James L.	89-0193M	5/31/89	Own Motion Order
McKenna, John J.	86-10091	9/1/89	Order of Dismissal
McKinney, Gerald	89-0246M	5/17/89	Own Motion Order
McKofka, Edward J.	89-0175M	5/17/89	Own Motion Order
McMahan, Elizabeth	87-13315	8/31/89	Order on Review
McMillan, Patrick	89-0208M	4/27/89	Own Motion Order
McMillion, Joan R.	85-01540	2/89	Order on Review
McMullen, John M.	88-0216M	1/89	Own Motion
McNeely, Ina	89-0470M	9/6/89	Own Motion Order
McPherson, Donald P.	89-0274M	5/31/89	Own Motion Order
McPherson, John C.	89-0123M	3,3/89	Own Motion
McQuillen, Richard	87-07645	8/31/89	Order on Review
McQuillen, Richard	87-07645	9/18/89	Order on Reconsideration
McRae, Billy	88-0768M	3/89	Own Motion
McRae, Billy	88-0768M	4/20/89	Own Motion Order on Recon
McSwain, Malcolm	88-0614M	1/89	Own Motion
Meadows, Betty	89-0059M	2/89	Own Motion
Melbye, Michael G.	87-17422	8/31/89	Order on Review
Mendoza, Serapio	88-20704	8/24/89	Order of Dismissal
Meredith, Patricia A.	86-17614	3/8/89	Order on Review
Meyers, Robert J.	89-0121M	3/89	Own Motion
Michael, Philip G.	87-03834	5/30/89	Order on Review
Michael, Vernon	89-0075M	2/89	Own Motion
Midwood, Evelyn A.	89-0525M	9/27/89	Own Motion Order
Miles, Donald R.	89-0169M	4/17/89	Own Motion Order
Miles, Lowa	89-0293M	8/23/89	Own Motion Order
Miller, Barbara	88-0549M	6/15/89	Own Motion Order
Miller, Dave	87-15250	8/31/89	Order on Review
Miller, Donald H.	87-14748	5/9/89	Order on Review
Miller, Gene P.	89-0182M	4/17/89	Own Motion Order
Miller, Guy A.	88-18516	6/21/89	Order of Dismissal
Miller, Steven A.	89-0439M	8/23/89	Own Motion Order
Mills, Donald R.	87-02797	2/23/89	Order on Review
Mills, Rosemary	87-01919	2/89	Order on Review
Millsap, Lawrence E.	88-0606M	1/89	Own Motion
Minear, Rodney J.	88-21246	5/17/89	Order of Dismissal
Mitchell, Charles P.	85-07024	4/25/89	Order Denying Reconsideration
Mitchell, Debbie K.	89-0484M	9/7/89	Own Motion Order
Mlasko, Rudolph R.	85-0406M	6/30/89	Own Motion Order

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Name	WCB Number	Date	Type of Order
Moffitt, Sterling	86-17346	5/3/89	Order of Dismissal
Monroe, Dean C.	88-0061M	8/11/89	Order Postponing Action
Montgomery, Robert E.	89-0283M	5/31/89	Own Motion Order
Mooers, Doris M.	89-00683	8/18/89	2nd Order of Dismissal
Mooers, Doris M.	89-00683	7/27/89	Order of Dismissal
Mooers, Doris M.	89-00683	8/7/89	Order Vacating Dismissal
Moore, Daniel P.	89-0013M	1/89	Own Motion
Moore, Harold R.	87-14422	9/26/89	Order on Review
Moore, Jack D.	86-0609M	3/89	Own Motion
Moore, James M.	87-06654	8/11/89	Order of Dismissal
Moore, Stephen H.	84-0532M	8/8/89	Own Motion Order
Moorhead, Thomas L.	88-16906	4/14/89	Order of Dismissal
Morgan, Owen B.	88-0795M	1/89	Own Motion
Morris, Arthur	89-0063M	2/89	Own Motion
Mosley, Robert	89-0179M	4/17/89	Own Motion Order
Mote-Harmon, Linda M.	89-0458M	8/24/89	Own Motion Order
Moyer, Phillip, Sr.	89-0209M	4/27/89	Own Motion Order
Mueller, Barbara	88-0596M	6/26/89	Own Motion Order
Mueller, Barbara	88-0596M	1/89	Own Motion
Mueller-Warthen, P.	87-18955	7/19/89	Order of Dismissal
Mullins, Patrick H.	87-05324	6/8/89	Order on Review
Munch-Kearl, Peggy S.	86-01897	2/24/89	Order on Review
Munch-Kearl, Peggy S.	86-01897	3/16/89	Order on Reconsideration
Murphy, Carol B.	88-16124	8/15/89	Order of Dismissal
Murphy, Shirley J.	88-13990 etc.	4/28/89	Amended Order of Dismissal
Murphy, Shirley J.	88-13990 etc.	4/12/89	Order of Dismissal
Murphy-Gelardi, P.	89-0170M	4/17/89	Own Motion Order
Murr, Marianne T.	87-19197	5/9/89	Order on Review
Murray, Vern	89-0349M	6/29/89	Own Motion Order
Myers, Donald	89-0035M	4/19/89	Own Motion Order
Myers, Kenneth W.	87-00812	5/17/89	Interim Order of Remand
Napier, Steven K.	86-13032	2/23/89	Order on Review
Neal, James	88-0137M	3/89	Own Motion
Neal, James W.	89-0341M	8/23/89	Own Motion Order
Nelke, Kristine	89-0365M	8/23/89	Own Motion Order
Nelson, Timothy J.	89-0267M	5/30/89	Own Motion Order
Nemec, Phillip	89-0092M	3/89	Own Motion
Newman, Sarah L.	87-0584M	3/89	Own Motion
Newton, Brian	89-0239M	5/9/89	Own Motion Order
Newton, Tracy F.	89-0476M	9/7/89	Own Motion Order
Nicholson, Randy L.	86-01438 etc.	1/89	Order on Review
Nicks, Edward	89-0053M	2/89	Own Motion
Nicks, Edward J.	89-0329M	6/30/89	Own Motion Order
Noah, Edward L.	89-0367M	7/13/89	Own Motion Order
Norbury, Sara	88-0335M	8/8/89	Own Motion Determination
Norris, Andrew C.	89-0350M	6/16/89	Own Motion Order
Norris, Thomas	89-0278M	5/30/89	Own Motion Order
North, Michael	88-0794M	1/89	Own Motion
Norvald, Gene H.	88-0817M	1/89	Own Motion
Norvald, Gene H.	89-0363M	6/16/89	Consent to Issuance
O'Mara, Richard A.	89-0129M	4/7/89	Own Motion Order
Obrist, Kenneth L.	83-03898	8/17/89	Order of Dismissal
Oden, James L.	89-0430M	8/22/89	Own Motion Order
Ohman, Christopher	89-0250M	6/15/89	Own Motion Order
Olin, Homer	89-0009M	4/5/89	Own Motion Order
Olinghouse, Barbara D.	86-01750	9/14/89	Order on Remand

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Name	WCB Number	Date	Type of Order
Oliver, Derek	89-0464M	8/25/89	Own Motion Order
Ollison, Vernetta	89-0498M	9/26/89	Own Motion Order
Orejel, Maria	88-19157	9/14/89	Order of Dismissal
Orozco, Antonia C.	89-01780	6/26/89	Order of Dismissal
Orr, Newton W.	84-05108	5/12/89	Order on Review
Ougheltree, Marie	89-0097M	3/89	Own Motion
Owens, Linda D.	88-0685M	2/89	Own Motion
Pacheco, Williadeane	88-0585M	1/89	Own Motion
Padilla, Rosanna	89-0217M	5/17/89	Own Motion Order
Padilla, Victor	88-0725M	1/89	Own Motion
Page, Roxanne	89-0475M	9/7/89	Own Motion Order
Pallas, Cheryl L.	88-18231	8/15/89	Order of Dismissal
Park, Roy	89-0468M	9/6/89	Own Motion Order
Parker, David L.	89-0085M	5/15/89	Own Motion Order
Parker, David L.	88-13890 etc.	5/15/89	Order on Review
Parker, David L.	88-13890 etc.	6/7/89	Order on Reconsideration
Parker, David L.	88-13890 etc.	5/30/89	Amended Order on Review
Parks, Duke	88-0181M	3/89	Own Motion
Parrish, Delano C.	89-0227M	5/17/89	Own Motion Order
Parrish, Dorothy	89-02591	7/18/89	Order of Dismissal
Partridge, Edward H.	86-16459	2/13/89	Order on Review
Patterson, Walter	89-0392M	7/31/89	Own Motion Order
Pavey, Henry W.	88-11925	5/3/89	Order of Dismissal
Payne, Ronald S.	88-17314	8/8/89	Order of Dismissal
Payne, Thelma Purcell	88-0506M	5/30/89	Own Motion Order
Peacock, James	87-0062M	2/89	Own Motion
Peck, Ida	89-0461M	8/23/89	Own Motion Order
Peck, Robert D.	89-0233M	5/17/89	Own Motion Order
Pelto, Gene M.	87-04397	3/89	Order on Review
Pendergrass, David	88-0827M	1/89	Own Motion
Perez, Alonzo	88-20567	7/27/89	Order Denying Motion to Dismiss
Perkins, Jon H.	87-08594 etc.	5/11/89	Order on Review
Perry, Alan L.	89-0342M	6/29/89	Own Motion Order
Persinger, Christopher	88-0793M	1/89	Own Motion
Peschel, Richard A.	87-07424	8/18/89	Order on Review
Peterson, Master Don	89-0356M	6/19/89	Own Motion Order
Peterson, Master Don M.	89-0356M	7/13/89	Own Motion Order on Recon
Phelps, Roby	89-0496M	9/7/89	Own Motion Order
Phibbs, Ross S.	87-07311	3/89	Order on Review
Philippi, Wesley	89-0056M	2/89	Own Motion
Phillips, Brian C.	89-0006M	1/89	Own Motion
Phillips, James E.	89-0090M	4/27/89	Own Motion Order
Phillips, Richard	89-0038M	4/27/89	Order Postponing Action
Phillips, Roger	89-0034M	2/89	Own Motion
Piluso, Carla C.	89-0437M	8/11/89	Own Motion Order
Pittman, Gary D.	89-0325M	6/1/689	Own Motion Order
Plaschka, Robert E.	87-0372M	4/7/89	Own Motion Order
Plemmons, Loreen H.	87-15554	3/89	Order on Review
Plemon, Vernon	87-14671	8/24/89	Order on Review
Poague, Robert	88-0129M	1/89	Own Motion
Pointer, Randy A.	87-15781 etc.	7/19/89	Order on Review
Pointer, Randy A.	87-15781 etc.	8/7/89	Amended Order on Review
Ponton, Jerry L.	88-22356	7/13/89	Order of Dismissal
Pool, Naomi	88-0762M	1/89	Own Motion
Porras, Maria R.	87-07390	4/25/89	Order on Review
Porter, Harris	87-0244M	4/17/89	Own Motion Order of Dismissal

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Porter, Richard	89-0241M	5/9/89	Own Motion Order
Powell, Edie L.	87-12237 etc.	8/18/89	Order on Review
Powers, Roland	88-0247M	3/89	Own Motion
Preston, Kenneth R.	89-0376M	8/23/89	Own Motion Order
Price, David	86-0422M	3/89	Own Motion
Price, Matthew	87-07326	8/31/89	Order on Review
Price, Ricky J.		3/89	Own Motion
Priest, Dennis L.	85-08762	7/13/89	Order of Dismissal
Prince, Darrell J.	86-17725	8/18/89	Order of Dismissal
Privatsky, Norman P.	89-0086M	3/89	Own Motion
Pullis, Wayne J.	88-17053	6/16/89	Order of Dismissal
Punneo, Claude Dean	89-0114M	3/89	Own Motion
Purdy, Rhonda E.	86-00412	3/16/89	Order on Review
Purdy, Rhonda E.	86-00412	4/17/89	Amended Order on Review
Puttie, Steven	88-0791M	2/89	Own Motion
Pyle, Henry	89-0141M	3/89	Own Motion
Quadros, Barbara	86-12705 etc.	6/8/89	Order on Review
Quindt, Charleene L.	88-07988	1/89	Order on Review
Quinn, A.J.	88-0528M	6/16/89	Own Motion Order of Dismissal
Quinn, Michael K.	87-00064	8/11/89	Order on Review
Raines, Carroll E.	87-05696	4/5/89	Order on Review
Ramano, Sandra L.	87-11766	8/18/89	Order on Review
Ramirez, Ricardo	89-0119M	3/89	Own Motion
Ramsay, Steven S.	89-0150M	7/5/89	Order Postponing Action
Ransom, Joyce R.	87-16734	8/15/89	Order on Review
Rard, John P.	89-0100M	3/89	Own Motion
Rard, John P.	89-0100M	9/27/89	Own Motion Determination/Recon
Rawlins, Richard T.	87-17935	8/23/89	Order on Review
Ray, Blenda Hadley	89-0497M	9/7/89	Own Motion Order
Ray, Gregory	89-0502M	9/27/89	Own Motion Order
Ray, Rodney	89-0165M	4/5/89	Own Motion Order
Ray, Sally	89-0142M	3/89	Own Motion
Rea, Linda	88-19811	5/31/89	Order of Dismissal
Read, Terry M.	89-0379M	7/13/89	Own Motion Order
Reavis, Lawrence	87-14533	6/8/89	Order of Dismissal
Reed, William M.	89-0399M	8/23/89	Own Motion Order
Regehr, Richard A.	87-13757	5/30/89	Order on Review
Reich, Teri L.	87-03355	6/12/89	Order on Review
Reid, Kenneth	89-0308M	6/15/89	Own Motion Order
Reinertsen, Judith	89-0127M	3/89	Own Motion
Reinertsen, Judith	89-0127M	4/17/89	Amended Denial of Consent
Reiserer, Deanna	87-07026	4/18/89	Order on Review
Repp, William	89-0203M	4/27/89	Own Motion Order
Reynolds, Keith W.	87-18861	8/24/89	Order on Review
Rhodes, Hoover	89-0108M	4/7/89	Own Motion Order
Richards, Stanley L.	88-0798M	1/89	Own Motion
Richardson, Phyllis	88-0471M	4/7/89	Own Motion Order
Richichi, Gary R.	87-09482	5/17/89	Order of Dismissal
Rictor, Donald A.	86-0244M	2/89	Own Motion
Riddell, Ray	89-0351M	6/29/89	Own Motion Order
Riley, John B., Sr.	87-0751M	1/89	Own Motion
Riley, Mary	88-15961	6/14/89	Amended Order of Dismissal
Riley, Mary	88-15961	5/31/89	Order of Dismissal
Rimer, Robert L.	89-0176M	4/17/89	Own Motion Order
Robbins, Douglas B.	87-13801	8/24/89	Order on Review
Roberts, Bruce	88-0815M	1/89	Own Motion

Name	WCB Number	Date	Type of Order
Roberts, Donald	88-0529M	1/89	Own Motion
Roberts, Richard A.	89-0416M	8/22/89	Order Postponing Action
Robertson, Audrey A.	87-11417	1/89	Order on Review
Robertson, Robert	89-0019M	2/89	Own Motion
Robinson, Everett E.	89-0282M	6/19/89	Order Awarding Attorney Fees
Robinson, Everett E.	89-0282M	5/26/89	Own Motion Order
Rodriguez, Guadalupe	89-0118M	3/89	Own Motion
Roesner, Robert W.	89-0449M etc.	8/10/89	Own Motion Order
Roesner, Robert W.	88-0579M	8/10/89	Own Motion Order
Rogers, Gayle K.	89-0405M	8/9/89	Own Motion Order
Rogers, Kenneth D.	87-08313 etc.	3/28/89	Order on Review
Rogers, Robert	89-0043M	5/17/89	Own Motion Order of Dismissal
Rohrich, Merle L.	87-04588 etc.	9/26/89	Order on Review
Romero, Paul V.	86-06047	8/24/89	Order on Review
Rosander, Ronald	89-0058M	4/27/89	Own Motion Order
Ross, Larry G.	89-0126M	3/89	Own Motion
Ross, Robert	89-0218M	5/17/89	Own Motion Order
Rossignol, Peggy	89-0275M	5/30/89	Own Motion Order
Rounsaville, Calvin	88-0383M	7/31/89	Own Motion Order
Rousseau, Leslie	88-12835	9/18/89	Order of Dismissal
Rucker, Beverly J.	88-21016	6/16/89	Order of Dismissal
Rudishauser, John M.	87-14770	8/24/89	Order on Review
Rumpel, Billie	89-0754M	2/89	Own Motion
Runey, Stevan	89-0057M	2/89	Own Motion
Sabey, Jimmy	88-0813M	1/89	Own Motion
Sackrider, Kenneth	89-0358M	7/13/89	Own Motion Order
Sallee, Glen D.	85-08042	5/30/89	Order on Review
Sanchez, Arthur	89-0147M	4/20/89	Own Motion Order of Dismissal
Sanchez, Enrique M.	84-0435M	3/89	Own Motion
Sandberg, Steven J.	87-05254	6/29/89	Order on Reconsideration
Sandberg, Steven J.	87-05254	6/13/89	Order on Review
Sanders, Jeffrey	87-03378	5/31/89	Order on Review
Sanders, Karen D.	89-0407M	8/25/89	Order Postponing Action
Sanders, Leonard L.	88-0717M	8/8/89	Own Motion Order
Sands, Howard A.	89-0457M	8/29/89	Order Postponing Action
Santibanez, Victor C.	87-15382	5/4/89	Order on Review
Sawyer, Danual R.	87-16823	8/23/89	Order on Review
Saxton, Lawrence	89-0138M	6/6/89	Own Motion Order
Schaffner, Gerald L.	88-19673	5/31/89	Order of Dismissal
Schehen, Sherwood	88-0634M	4/20/89	Own Motion Order
Schmidt, Marlene G.	89-0173M	3/89	Own Motion
Schmidt, Myron A.	89-0040M	4/27/89	Order Postponing Action
Schmidt, Myron A.	89-0040M	5/12/89	Own Motion Order
Schmidt, Myron A.	89-0040M	6/12/89	Own Motion Order on Recon
Schneider, Richard	88-0804M	5/26/89	Own Motion Order
Schooling, Mary E.	86-14712	4/5/89	Order on Review
Schooling, Mary E.	86-10542	4/5/89	Order on Review
Schulenburg, Charles C.	86-15742	7/27/89	Order on Review
Schuster, Danny	89-0226M	5/17/89	Own Motion Order
Schwab, Donald F.	87-02450	6/8/89	Order on Review
Schwarz, Denise K.	86-16364	2/24/89	Order on Review
Scott, Hal W.	89-0396M	8/11/89	Own Motion Order
Scott, James H.	88-13949	5/23/89	Order of Dismissal
Scronce, Carrol J.	89-0480M	9/7/89	Own Motion Order
Searle, Albert	88-0503M	9/20/89	Own Motion Order
Self, Ira	88-0577M	3/89	Own Motion

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Selman, Thomas	89-0167M	5/30/89	Own Motion Order on Recon
Sevey, Gene	89-0004M	1/89	Own Motion
Sharman, Donald R.	88-0778M	3/89	Own Motion
Shellito, Delbert C.	87-05284	6/13/89	Order on Review
Shellito, Delbert C.	87-05284	7/12/89	Amended Order on Review
Sherburn, Jackie	88-18659	9/18/89	Order of Dismissal
Sheridan, Sherry A.	89-02146	8/11/89	Interim Order of Dismissal
Sherman, Harvey L.	88-0566M	3/89	Own Motion
Sherman, James C.	87-0128M	5/30/89	Own Motion Order
Sherman, James C.	87-01094 etc.	5/30/89	Order on Review
Sherman, William L.	87-11797 etc.	3/23/89	Order on Review
Sherratt, Pamela L.	88-0526M	3/89	Own Motion
Shields, William T.	87-03693 etc.	1/5/89	Order on Review
Shiffer, John	88-0782M	3/89	Own Motion
Shockley, Douglas E.	89-0140M	8/23/89	Own Motion Order
Shuler, Susan E.	86-16034	2/23/89	Order on Review
Shuttlesworth, Larry D.	87-01710	4/17/89	Order on Reconsideration
Shuttlesworth, Larry D.	87-01710	3/89	Order on Review
Silvers, Orlan	86-0608M	2/89	Own Motion
Simington, Timothy O.	87-09608	9/20/89	Order on Review
Simmons, Roy D.	87-0696M	2/89	Own Motion
Simnitt, Nancy S.	86-0052M	3/89	Own Motion
Simon, Lyle	89-0307M	5/30/89	Own Motion Order
Simons, Scott M.	86-13725 etc.	4/21/89	Order on Review
Singleton, Leslie A.	86-04006	8/17/89	Order on Review
Skaggs, Leah	89-0225M	5/17/89	Own Motion Order
Skinner, Catherine	88-0531M	7/13/89	Own Motion Determination
Slater, Alice E.	86-11313	4/21/89	Order on Review
Slay, Charles B.	87-16677	8/17/89	Order on Review
Slayton, Ellen	88-0519M	1/89	Own Motion
Slinger, Edward	89-0148M	3/89	Own Motion
Smith, Christine	89-0091M	3/89	Own Motion
Smith, Evelyn	89-0133M	3/89	Own Motion
Smith, John W.	89-0231M	5/17/89	Own Motion Order
Smith, Raymond G.	87-10599	8/31/89	Order on Review
Smith, Roger (Gravelle)	88-09288	7/13/89	Order of Dismissal
Smith, Willard	87-0537M	1/89	Own Motion
Smouse, Judy	89-0087M	3/89	Own Motion
Snyder, Thomas C.	89-0436M	8/23/89	Own Motion Order
Solesbee, Keith	88-05751	5/4/89	Order of Dismissal
Sorrels, Michael A.	87-15688	1/89	Order on Review
Southworth, Everett	88-0502M	3/89	Own Motion
Spain, John K.	89-0313M	6/12/89	Own Motion Order
Spangler, Warren L.	87-0535M	8/18/89	Own Motion Order on Recon
Spence, Paul E.	87-0373M	1/89	Own Motion
Spencer, Robert R.	89-0104M	3/89	Own Motion
Spivey, Harvey F.	85-0615M	3/89	Own Motion
Sportsman, Rex	89-0181M	4/27/89	Own Motion Order
Spunagle, Jeannie E.	88-21629	8/8/89	Order of Dismissal
Stafford, Everett E.	86-17265	7/12/89	Order of Dismissal
Stark, Susan K.	86-05043	3/89	Order on Review
Stavang, W.L.	89-0492M	9/7/89	Own Motion Order
Stenzel, Ronald	89-0098M	3/89	Own Motion
Stephens, Larry C.	87-0341M	9/28/89	Own Motion Order
Stephens, Samuel R.	89-0506M	9/27/89	Own Motion Order
Stephens, Williams	88-0820M	1/89	Own Motion

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Stephenson, Beverly	89-0200M	4/13/89	Own Motion Order
Sterba, Gary	89-0067M	2/89	Own Motion
Stevens, Rick D.	89-07555	8/8/89	Order of Dismissal
Stevenson, Barbara J.	87-14606 etc.	3/89	Order on Review
Steward, Richard	89-0252M	5/26/89	Own Motion Order
Stewart, Bearl	89-0270M	7/21/89	Own Motion Order
Stewart, Edna	87-08536	8/17/89	Order on Review
Stibik, David	88-0081M	2/89	Own Motion
Stines, Nancy	89-0232M	5/17/89	Own Motion Order
Stockebrand, Keith L.	88-0432M	3/89	Own Motion
Storms, Lenora	89-0305M	5/23/89	Denial of Consent
Stovall, Pamela R.	85-01254 etc.	9/19/89	2nd Order on Remand
Strain, Patrick L.	86-09967	6/8/89	Order on Review
Strauss, Steven J.	89-0122M	3/89	Own Motion
Streit, Ronald R.	84-0455M	9/26/89	Own Motion Determination
Strong, Jerry	89-0519M	9/29/89	Own Motion Order
Stuck, Elizabeth	89-0302M	6/15/89	Own Motion Order
Sturgis, Vi	87-05517	6/12/89	Order on Review
Sturtevant, Bill M.	85-15646	8/8/89	Order on Review
Sunderland, Wayne G.	86-0478M	4/4/89	Own Motion Order of Dismissal
Sundstrom, Leland R.	86-14782	3/89	Order on Review
Surface, Leland S.	87-01765	2/89	Order on Review
Sutton, Donna J.	86-16464	3/89	Order on Review
Sutton, Donna J.	86-16464	4/12/89	Order on Reconsideration
Swanberg, Betty J.	83-0281M	3/89	Own Motion
Swank, Donald L.	86-0261M	6/12/89	Own Motion Determination
Sweeney, Kathy A.	87-0571M	3/89	Own Motion
Swift, Clay	89-0352M	8/25/89	Own Motion Order
Swinney, Reuben	89-0414M	8/9/89	Own Motion Order
Talley, Stanley W.	87-11371 etc.	8/11/89	Interim Order of Remand
Tano, Benny Y.	89-0485M	9/7/89	Own Motion Order
Tarpley, Gary	89-0132M	3/89	Own Motion
Taylor, David M.	88-15019 etc.	6/16/89	Order of Dismissal
Teague, Webster J.	85-06785	3/89	Order on Review
Terlouw, Vera C.	87-03443	7/5/89	Order of Dismissal
Terlouw, Vera C.	87-03443	7/27/89	Order Denying Motion
Terramagra, Elizabeth .	87-07053	8/17/89	Order on Review
Thissell, John, Sr.	88-0727M	3/89	Own Motion
Thompson, Albert	89-0487M	9/26/89	Own Motion Order
Thompson, Ernest E.	85-07828	3/8/89	Order on Remand
Thompson, Ernest E.	85-07828	3/16/89	2nd Order on Remand
Thompson, Jerome S.	87-01681	2/89	Order on Review
Thompson, Johnny L.	88-21632 etc.	9/27/89	Order of Dismissal
Thorp, Frank	89-0443M	8/23/89	Own Motion Order
Thorsen, Carmen J.	89-0364M	8/23/89	Own Motion Order
Thrasher, Ronald W.	86-0696M	3/89	Own Motion
Thurston, Eleanor M.	86-05028 etc.	9/1/89	Order on Remand
Thurston, Lewis	87-0686M	3/89	Own Motion
Tienken, Myrna J.	87-19048	8/8/89	Order on Review
Tila, Raimo	89-0018M	1/89	Own Motion
Tilton-Kidd, Doris	88-0166M	3/89	Own Motion
Timpy, Charles	84-0530M	3/89	Own Motion
Tindall, James	88-0095M	5/30/89	Own Motion Order
Toftner, Linda M.	89-0479M	9/7/89	Own Motion Order
Tompkins, Nora A.	86-14921	6/21/89	Amended Order on Review
Tompkins, Nora A.	86-14921	6/8/89	Order on Review

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Tovar, Seferino J.	88-16611 etc.	5/5/89	Order of Dismissal
Townsend, Rick T.	87-12762	6/13/89	Order on Review
Trafton, Leonard F.	86-13723	3/2/89	Order on Review
Trollope, Stephen W.	88-0146M	3/89	Own Motion
Trowbridge, Jimmy W.	87-0569M	9/18/89	Own Motion Determination
Tu, Hung M.	89-04246	8/24/89	Order of Dismissal
Turchy, Frank	88-0037M	3/89	Own Motion
Turner, Ronald J.	87-04630	2/23/89	Order on Review
Turner, Ronald J.	87-04630	3/13/89	Order on Reconsideration
Turner, Ronald J.	87-04630	4/19/89	Amended Order on Reconsideration
Tuttle, David	88-0746M	1/89	Own Motion
Ulman, Eva	89-0447M	8/23/89	Own Motion Order
Ultsch, Bruce	89-0093M	3/89	Own Motion
Underhill, Thelma	88-0486M	8/11/89	Own Motion Order
Unga, Makihele	87-17801	8/17/89	Order on Review
Van Winkler, Joy	89-0211M	5/17/89	Own Motion Order
VanBurger, Earl D.	87-0520M	3/89	Own Motion
Vance, Robert E.	86-0260M	3/89	Own Motion
Vandehey, Joey R.	89-0195M	4/27/89	Own Motion Order
Vanderpool, William	88-0811M	1/89	Own Motion
Vangroll, Rebecca B.	89-0384M	8/22/89	Order Postponing Action
Vanhoof, Ralph W.	89-0446M	8/11/89	Own Motion Order
VanHorn, Karen L.	89-04133	6/16/89	Order of Dismissal
Vanni, Lisa	88-14234	5/11/89	Order of Dismissal
Vanzant, Timothy R.	88-0631M	3/89	Own Motion
Varga, Carol J.	89-02587	9/14/89	Order of Dismissal
Vatland, Milnar	87-0603M	3/89	Own Motion
Veatch, Thomas J.	87-06295	8/8/89	Order on Review
Vick, Linda	86-15972	2/24/89	Order on Review
Vilches, Alfonso	89-0258M	5/26/89	Own Motion Order
Vincent, Debbie	89-0445M	8/29/89	Own Motion Order
Vranizan, James	88-0599M	7/11/89	Own Motion Order
Waddell, Ralph	89-0160M	3/89	Own Motion
Wade, Bonnie	89-0324M	6/15/89	Own Motion Order
Wainwright, Charles	88-0548M	1/89	Own Motion
Wakeley, Alfred F.	86-17787	5/31/89	Order on Review
Wall, Robert N.	89-0124M	3/89	Own Motion
Walsh, Marie C.	86-17420	3/20/89	Order on Reconsideration
Walsh, Marie C.	86-17420	3/8/89	Order on Review
Walsh, Marjorie R.	85-0680M	3/89	Own Motion
Ward, Kathryn M.	88-22215	7/11/89	Order of Dismissal
Ward, Raymond P.	87-15159	8/24/89	Order on Review
Warf, Steven	88-0213M	3/89	Own Motion
Warfel, Ermagene	87-05941	6/8/89	Order of Dismissal
Warnack, Sheila	89-0465M	9/6/89	Own Motion Order
Warnock, Keith	89-0279M	5/30/89	Own Motion Order
Warren, Guadalupe	86-13579	3/12/89	Order on Review
Warren, William V.	87-13829 etc.	6/21/89	Order on Review
Watkins, Paul	89-0249M	5/30/89	Amended Own Motion Order
Watkins, Paul	89-0249M	5/17/89	Own Motion Order
Watson, John D.	89-0469M	9/7/89	Own Motion Order
Watson, Michael A.	89-0229M	5/17/89	Own Motion Order
Watts, Shirley	89-0220M	5/3/89	Own Motion Order
Webb, Andy	88-0144M	1/89	Own Motion
Webber, Richard	88-0571M	3/89	Own Motion
Welch, Kent W.	89-0495M	9/7/89	Own Motion Order

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Wells, Fred E.	87-02021 etc.	3/2/89	Order on Review
Wells, Fred E.	87-02021 etc.	2/23/89	Amended Order on Review
Wesel, Billy J.	89-0372M	7/13/89	Own Motion Order
West, Alfred	87-0605M	4/17/89	Own Motion Order
West, Wesley	87-05649	6/16/89	Order on Review
Westfall, Marion	88-0819M	1/89	Own Motion
Wheeler, Charley A.	87-11106	6/8/89	Order on Review
Wheeler, Harriette	88-0046M	4/17/89	Own Motion Order
Wheeler, William B.	87-00392	5/26/89	Corrected Order on Review
Wheeler, William B.	87-00392	5/17/89	Order on Review
Whitaker, Gloria	89-0125M	3/89	Own Motion
Whitlow, David L.	86-14624	2/89	Order on Review
Wigle, Joseph	88-0588M	1,2/89	Own Motion
Wilbanks, Dan	89-0425M	8/11/89	Own Motion Order
Wilbanks, Danny	88-0649M	3/89	Own Motion
Wilcox, Mary L.	87-01597	4/25/89	Order on Review
Wilcox, Shirley A.	87-09028 etc.	3/8/89	Order on Review
Wilder, William D.	84-11216	3/89	Order on Review
Wilding, Debbie A.	87-00184	2/89	Order on Review
Wiley, Rick L.	88-05948	8/15/89	Order of Dismissal
Wilkerson, Barbara J.	86-07372	1/89	Order on Review
Wilkinson, Elizabeth L.	89-0422M	8/9/89	Order Postponing Action
Wilkinson, Franklin D.	89-0385M	7/19/89	Own Motion Order
Williams, Arbra	88-0743M	2/89	Own Motion
Williams, Floyd	89-0266M	6/6/89	Own Motion Order
Williams, Mary E.	87-00078	1/5/89	Order on Review
Williams, Steven E.	87-08779	8/18/89	Order on Review
Willman, Thomas	89-0144M	5/31/89	Own Motion Order
Wilson, David	89-0042M	2/89	Own Motion
Wilson, Ralph E.	87-07590	6/6/89	Order on Review
Wilson, William	89-0310M	6/12/89	Order Postponing Action
Windom, Walter	89-0088M	3/89	Own Motion
Winkle, Jerry	89-0030M	6/23/89	2nd Own Motion Order
Winkle, Jerry	89-0030M	6/12/89	Own Motion on Recon
Winningham, Bret G.	89-0515M	9/27/89	Own Motion Order
Winters, Tom N.	89-0185M	4/17/89	Own Motion Order
Wolever, Arlene	89-0216M	5/17/89	Own Motion Order
Wood, Edward	89-0262M	8/23/89	Own Motion Order
Wood, Joan M.	89-0061M	2/89	Own Motion
Woods, Dorothy	89-0264M	5/23/89	Order Postponing Action
Woods, Stanley W.	89-0491M	9/7/89	Own Motion Order
Wooldridge, Michael	89-0248M	5/17/89	Own Motion Order
Woolridge, Michael	87-0577M	3/89	Own Motion
Wright, Gary D.	86-11840	3/89	Order on Review
Wright, Terry	89-02123	8/31/89	Order of Dismissal
Wrinkle, Robert W.	89-0184M	5/17/89	Own Motion Order of Dismissal
Yakes, Audrey	88-0765M	1/89	Own Motion
Ybarra, Manuel A.	89-0489M	9/26/89	Own Motion Order
Yost, Steven J.	89-0528M	9/29/89	Own Motion Order
Young, Gail	89-0020M	1/89	Own Motion
Yuille, Michael	89-0242M	5/9/89	Own Motion Order
Zable, Isabel	89-0294M	6/15/89	Own Motion Order
Zapien, Guadalupe	87-02467	9/14/89	Order on Review
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