



# News & Case Notes

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**BOARD NEWS**

## Settlements: (“009-0015”) - Notify Board Immediately

Parties/practitioners are reminded of their obligation to promptly notify the Board whenever they have reached (or are in negotiations to reach) a settlement that will resolve issues pending before the Board and/or the Hearings Division. See OAR 438-009-0015(1), (2). Any delay in providing this notification can be particularly onerous on the Board Members and their review staff, who may be engaged in significant review/research/deliberations concerning the “settled” or “possibly settled” case. Prompt notification of the parties’ “tentative” or “possible” settlement, will allow the Members and staff to defer action on the case and turn their attention to other pending and “unsettled” cases.

Consequently, whenever parties/practitioners are in the process of reaching a settlement (or have reached a settlement in principle) that effects issues that are pending Board review, they are asked use the Board’s online services via its website (which allows for notification if a case has settled or is being withdrawn), or call Karen Burton, WCB’s Executive Secretary, at (503)934-0123. They will also be asked to send in a letter, confirming this notification. Parties/ practitioners’ cooperation with this request is greatly appreciated.

## Changes to “Hearings Division” Procedures - (OAR 438-005-0035, OAR 438-006-0031, OAR 438-006-0036, and OAR 438-006-0045)

### Introduction

After considering public comments in response to its “rule review” process, the Board proposed several amendments to its administrative rules. Following a rulemaking hearing and further deliberations, the Board has adopted a number of permanent amendments to its rules, some of which concern the above-mentioned rules.

These rule amendments are designed to further promote communication between the parties concerning issues/relief and responses to be addressed at hearing and to reduce situations in which one party is surprised at hearing by an issue or response raised by the other party. The summary below presents an overview of these rule changes. These amendments are effective April 1, 2014, and apply to all requests, responses, and clarification motions that concern hearing requests filed on or after April 1, 2014. See WCB Admin. Order 2-2013, eff. 4/1/2014.

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Board's Policy - Specificity of Issues/Relief and Responses - OAR 438-005-0035

The Board's policy is to promote the full and complete disclosure of a party's *specific position* concerning the issues raised and relief requested in a specification of issues under OAR 438-006-0031 and in a response under OAR 438-006-0036. The intent of this policy is to clarify the scope of the matters to be litigated; it is expressly *not* to create binding admissions on behalf of any party. See OAR 438-005-0035(4).

The Board recognizes the complexity of disputed claims and the time limitations concerning the scheduling and litigation process for such claims. Therefore, as factual, medical, and legal aspects of disputed issues evolve, the amendment of issues, relief requested, theories, and defenses *may* be allowed as prescribed in OAR 438-006-0031(2) and OAR 438-006-0036(2). See OAR 438-005-0035(5).

Specification of Issues - OAR 438-006-0031

The request for hearing under OAR 438-005-0070 must be filed on a form prescribed by the Board and *shall* include a specific listing of all issues to be raised at the hearing and all relief requested. See OAR 438-006-0031(1). However, failure to include such a listing is not jurisdictional.

Amendments to the initial hearing request *may be allowed*, subject to a motion by an adverse party for a postponement under OAR 438-006-0081 or a continuance under OAR 438-006-0091. See OAR 438-006-0031(2). "May be allowed" replaces "shall be freely allowed" in the rule. In addition, if, during the hearing, the evidence supports an issue(s) not previously raised, the ALJ may allow the issue(s) to be raised and may continue the hearing under OAR 438-006-0091. See OAR 438-006-0031(2).

Response - OAR 438-006-0036

Not later than *21 days after the issuance of the Notice of Hearing under OAR 438-006-0020*, a party defending against a request for hearing *shall*, on a form prescribed by the Board, file with the Board and simultaneously serve on all other parties a response specifying its position on the issues raised and relief requested and any additional issues raised and relief requested by the respondent. See OAR 438-006-0036(1).

The previous version of the rule provided a deadline of "15 days after receiving the listing of issues and other information required by OAR 438-006-0031." In making this change, the Members reasoned that such a change will further promote the Board's policy of full and complete disclosure of a party's response under OAR 438-006-0036.

In addition, this response is "subject to OAR 438-006-0045(2)," which, as addressed below, provides for "motions for clarification" as a means to address disputes concerning the specification of issues and responses. See OAR 438-006-0036(1); OAR 438-006-0045(2).

Amendments to this response *may be allowed*, subject to a motion by an adverse party for a postponement under OAR 438-006-0081 or a continuance under OAR 438-006-0091. See OAR 438-006-0036(2). As noted in the section

regarding OAR 438-006-0031(2), this represents a change from previous language providing that amendments “shall be freely allowed.” Finally, if, during the hearing, the evidence supports an issue(s) not previously raised, the ALJ may allow the issue(s) to be raised and may continue the hearing under OAR 438-006-0091. See OAR 438-006-0036(2).

#### System to Resolve Disputes - Motions, Arguments - OAR 438-006-0045

To implement its policy to promote full and complete disclosure of a party’s positions before the hearing, the Board has prescribed a system under OAR 438-006-0045 to address disputes concerning the specification of issues and responses.

Under this system, a party may file a motion for clarification of the issues raised and relief requested by any party in a specification of issues under OAR 438-006-0031 or a response under OAR 438-006-0036. See OAR 438-006-0045(2). That motion will be denied, unless the moving party files a certificate verifying a good faith effort to confer with the other party in an attempt to clarify the issues raised and relief requested. See OAR 438-006-0045(3). This section is designed to ensure that parties have attempted to resolve their dispute on an informal basis *before* seeking ALJ participation.

The ALJ shall consider the Board’s policy in OAR 438-005-0035 in resolving a motion for clarification under section (2). See OAR 438-006-0045(4). In addition, a party’s failure to reasonably respond to a clarification request may be grounds for a postponement under OAR 438-006-0081 or a continuance under OAR 438-006-0091. See OAR 438-006-0045(5).

### **CASE NOTES**

## Claim Disposition Agreement: “Final” PPD Award - Not Separate “Consideration” for CDA

*Karen S. Standridge*, 66 Van Natta 156 (January 27, 2014). In approving a Claim Disposition Agreement (CDA) under ORS 656.236(1), the Board held that the carrier’s agreement to pay permanent disability (PPD) benefits that had been awarded by a final Notice of Closure (NOC) did not constitute valid consideration for claimant’s release of “non-medical service-related” benefits. The parties submitted a proposed CDA, which provided that claimant would receive her entire PPD award that had been granted by a previous final NOC, as well as additional monetary proceeds.

The Board approved the CDA based only on the additional proceeds. Citing *Robert Derderian*, 45 Van Natta 1042 (1993), and *George T. Taylor*, 43 Van Natta 676 (1991), the Board stated that temporary or permanent disability benefits that are legally due and payable before the submission of a CDA may not be treated as separate consideration or an “advancement” for a CDA and its proceeds.

*Temporary/permanent disability benefits that are due and payable before CDA is submitted to the Board may not be treated as separate consideration or an “advancement” for a CDA.*

Applying the aforementioned rationale to the proposed CDA, the Board noted that there was no indication that a request for reconsideration of the NOC had been timely filed. See ORS 656.268(5)(c). Reasoning that the carrier's obligation to pay claimant's PPD benefits had become final, the Board concluded that the carrier's agreement to pay the remaining balance of the final award did not constitute "consideration" for the CDA. Instead, the Board interpreted the provision as an acknowledgment of the carrier's ongoing responsibility to pay the remainder of final PPD award. Nevertheless, the Board approved the CDA, concluding that the additional monetary proceeds (beyond the PPD payments) constituted valid consideration for the disposition.

Hearing Procedure: Failure to Appear  
at Hearing - Assisting Sick Child -  
"Extraordinary Circumstances" - Justified  
"Postponement"

Course & Scope: "Intentional Injury" -  
"156(1)" - Carrier Must Overcome Rebuttable  
Presumption That Injury Was Not "Willfully"  
"Self-Inflicted"; Claimant's "Auger" Injury  
"Course of" Employment - Did Not "Exceed  
Bounds" of Employment

*Larry Brown*, 66 Van Natta 95 (January 16, 2014). Analyzing OAR 438-006-0081(1), and OAR 438-006-0071, the Board held that claimant's failure to appear at a scheduled hearing regarding his appeal of a carrier's injury denial was justified because he was attending to the needs of his sick child and, as such, he had established "extraordinary circumstances" beyond his control warranting a postponement of the hearing. Claimant filed a claim, asserting that he had been injured when the lid of an auger he had been leaning against fell on his thumb. The carrier denied the claim, contending that he had intentionally placed his thumb into a hinge of the auger and forced the lid to fall on it or he was outside the bounds of his employment at the time of the injury. Thereafter, claimant requested a hearing, which he did not attend because his son had become ill while staying with claimant's sister, who had called him to pick up his son the morning of the hearing. After claimant sought to have the hearing reset, the carrier objected, contending that he had not established extraordinary circumstances for his failure to appear at the initially-scheduled hearing. Finding claimant's sister's testimony regarding his sick child to have been credible (based on her demeanor), the ALJ determined that extraordinary circumstances had been established (justifying the postponement of the hearing). Furthermore, unpersuaded that claimant's injury had been intentional, the ALJ set aside the carrier's denial.

On review, the Board affirmed. Citing OAR 438-006-0071 and *Kenneth M. Porter*, 60 Van Natta 370 (2008), the Board stated that, in the absence of a finding of “extraordinary circumstances,” a represented claimant’s failure to appear at a scheduled hearing is treated as a waiver of the right to testify and the record is based on the exhibits submitted for presentation at the scheduled hearing. Relying on OAR 438-006-0081(1), and *Grinstead v. Lacamas Laboratories, Inc.*, 212 Or App 408, 413 (2007), the Board noted that it reviews an ALJ’s “extraordinary circumstances” to justify a postponement of a scheduled hearing on a *de novo* basis.

*Claimant’s need to respond to his child’s illness constituted extraordinary circumstances beyond his control justifying the postponement of his scheduled hearing.*

Turning to the case at hand, the Board acknowledged that there were some inconsistencies in claimant’s testimony regarding when he contacted his former attorney and sister on the morning of the scheduled hearing and whether he reached them by means of a phone or texting. Nonetheless, emphasizing that the ALJ had found claimant’s sister’s testimony to have been credible (based on her demeanor) and finding no persuasive evidence not to defer to that credibility assessment, the Board concluded that claimant’s son’s illness constituted extraordinary circumstances justifying the postponement of his scheduled hearing. See *Cynthia Yerton*, 61 Van Natta 1581, 1585 (2009); *Frances J. McDonald*, 42 Van Natta 1349 (1990); *Betty A. Delgado*, 42 Van Natta 443 (1990).

*Test for determining whether an injury was intentional is: (1) whether claimant’s condition was result of his/her conscious volitional act; and (2) whether claimant had knowledge of the consequences of the act.*

Addressing the carrier’s contention that claimant’s thumb injury had been intentional, the Board stated that, pursuant to ORS 656.156(1), an injury is not compensable if it results “from the deliberate intention of the worker to produce such injury.” Citing ORS 656.310(1)(b), and *Nathaniel D. Hardy*, 63 Van Natta 1977, 1979 (2011), *aff’d without opinion*, 252 Or App 750 (2012), the Board noted that there is a “rebuttable presumption” that an “injury was not occasioned by the willful intention of the injured worker to commit self-injury.” Referring to *James G. Wesley*, 40 Van Natta 1841, 1844 (1988), the Board reiterated that the test for determining whether a claimant’s injury was intentional is: (1) whether claimant’s condition was the result of his/her conscious, volitional act; and (2) whether claimant had knowledge of the consequences of the act.

*Carrier did not rebut presumption against an intentional injury under ORS 656.310(1)(b).*

Applying those principles to the present case, the Board determined that the carrier had not rebutted the presumption against an intentional injury. See ORS 656.310(1)(b). The Board acknowledged the employer’s president’s testimony that leaning against the auger would not make the lid fall over and that it was not natural for a thumb to be placed inside the machine. The Board further recognized that the employer had presented a DVD copy that its president described as showing that the machine was being violently shaken when the lid came down. Nonetheless, the Board noted that the president had not witnessed claimant’s injury. Moreover, after reviewing the DVD copy, the Board was unable to determine who (or what) had caused the machine to shake. Finally, as the employer’s president had admitted, the Board agreed with the ALJ’s description that claimant was not depicted in the DVD copy when the lid was closed.

Based on its review, the Board found the evidence insufficient to establish that claimant had intentionally caused the lid of the machine to fall on his thumb. Accordingly, the Board concluded that the carrier had not rebutted the presumption against a finding that his injury was willfully, self-inflicted.

Finally, the Board rejected the carrier's contention that claimant's injury did not occur in the course of his employment because his work assignment did not involve the auger and he was outside the bounds of his employment at the time of his injury. After reviewing the testimony from claimant and his supervisor, the Board reasoned that, even if it was not expected that claimant would be leaning against the auger, the supervisor's testimony was insufficient to rebut claimant's testimony that he was by the machine to ask a coworker for assistance regarding his assignment.

*Because claimant was seeking information regarding his next task when he was injured, he was not acting outside the normal boundaries of his work at the time of his injury.*

Rather than performing an unauthorized or prohibited task at the time of his injury, the Board determined that claimant's injury had taken place within the period of his employment, at a place where he was reasonably expected to be, and while he was reasonably fulfilling the duties of his employment or doing something reasonably incidental to it; *i.e.*, seeking information regarding his next task. Consequently, the Board concluded that claimant was not acting outside the normal boundaries of his work at the time of his injury, but instead his injury had occurred within the course of his employment. *Fred Meyer, Inc. v. Hayes*, 325 Or 592, 598 (1997); *Pamela Huston*, 65 Van Natta 1622, 1626 (2013).

## Own Motion: PPD - Impairment Findings - Lower Extremity "Strength Loss" - "035-0230(11)" - "Extensive Arthritis" Requirement Not Satisfied

*Karen L. Puller*, 66 Van Natta 58 (January 10, 2014). Applying OAR 436-035-0230(11), the Board held that claimant was not entitled to a "strength loss" award for her foot (ankle/leg) because her impairment findings did not support a diagnosis of "extensive arthritis" nor the presence of secondary strength loss, chronic effusion, or varus/valgus deformity. After her 5-year aggravation rights expired regarding her ankle fracture (which eventually resulted in an ankle fusion), her Own Motion claim was voluntarily reopened for osteoarthritis of several ankle joints, as well as subtalar arthrodesis. Following a Notice of Closure that awarded increased scheduled permanent disability for her ankle/leg, claimant requested Board review, seeking an additional award. Referring to a medical arbiter's description of "documented" arthritis in her ankle, claimant sought a "strength loss" award under OAR 436-035-0230(11).

*When arbiter did not diagnose "extensive arthritis" or make descriptive/qualifying statements regarding arthritis, a "strength loss" award under "035-0230(11)" for a leg condition is not warranted.*

The Board denied claimant's request. Citing OAR 436-035-0230(11), the Board stated that a 5 percent impairment value is available for a diagnosis of Grade IV chondromalacia, extensive arthritis, or extensive degenerative joint disease in the ankle/knee when one or more of the following conditions is present: (1) secondary strength loss; (2) chronic effusion; or (3) varus or valgus deformity less than found in section (4) of the rule. Relying on *Gary D. Moser*, 65 Van Natta 1669, 1674 (2013), the Board noted that, when a medical arbiter did not diagnose "extensive arthritis" or make descriptive or qualifying statements regarding the arthritis, a "strength loss" award for a leg condition was not appropriate.

Turning to the case at hand, the Board acknowledged the arbiter's reference to "documented subtalar, talonavicular, and naviculocuneiform arthritis." Nonetheless, the Board noted the absence of a diagnosis of "extensive arthritis," as well as no reference to the presence of any of the rule's specific conditions (secondary strength loss, chronic effusion, or varus/valgus deformity). Moreover, the Board observed that, in response to a question regarding the rule's requirements, the arbiter had considered the question invalid because "there is no remaining ankle joint or cartilage secondary to the arthrodesis procedure performed in 1988 \* \* \*."

Based on the arbiter's opinion, the Board determined that the rule requirements had not been satisfied. Reasoning that it could not substitute its opinion for that of the arbiter's, the Board concluded that claimant was not entitled to a strength loss award for her ankle/leg.

*Because a previous arthrodesis had treated subtalar arthritis and arbiter documented a loss of strength due to fused ankle, dissent contested that "strength loss" requirement under "035-0230(11)(a)" had been satisfied.*

Member Weddell dissented. Based on the arbiter's reference to "right ankle osteoarthritis of the subtalar, talonavicular and navicular cuneiform joints," Weddell asserted that these accepted conditions constituted "extensive arthritis." Furthermore, Member Weddell noted that claimant's 1988 arthrodesis surgery had been performed to treat the subtalar arthritis. Finally, because the arbiter had documented a loss of strength due to claimant's fused ankle, Member Weddell contended that the requirements for a strength loss award under OAR 436-035-0230(11)(a) had been satisfied.

## Premature Closure: "Medical Sequela" of Accepted Condition - Not "Medically Stationary" at Claim Closure

*Sarah E. Morgan*, 66 Van Natta 165 (January 27, 2014). Applying ORS 656.268(1)(a), the Board held that claimant's injury claim for a right ankle condition was prematurely closed because a "direct medical sequela" of that accepted condition (reflex sympathetic dystrophy (RSD) or a nerve injury) were not medically stationary at claim closure. After the carrier accepted several ankle conditions, claimant underwent surgery. Subsequently, the claim was closed, based on a physician's determination that she was malingering and that her ankle condition was medically stationary. Thereafter, a consulting pain specialist reported that claimant's ongoing pain symptoms resulted from either RSD or a skin nerve, which had been cut during the surgery. Based on claimant's attending physician's concurrence with the specialist's opinion, an Order on Reconsideration rescinded the Notice of Closure. The carrier requested a hearing, contending that no "direct medical sequela" had been established and, as such, claimant's accepted condition was medically stationary at claim closure.

The Board disagreed with the carrier's contention. Citing ORS 656.268(1)(a), the Board stated that claim closure is authorized when a claimant's condition has become medically stationary and there is sufficient information to determine impairment. Relying on ORS 656.005(17), the Board noted that "medically stationary" means that no further material improvement would reasonably be expected from medical treatment or the passage of time. Referring to *Manley v. SAIF*, 181 Or App 431, 437-39 (2002), the Board

*Because claimant's RSD or skin nerve injury was caused by accepted condition or surgery, Board found that record "clearly established medically" that a "direct medical sequela" was not medically stationary at claim closure.*

remarked that if an accepted condition has a "direct medical sequela," the sequela must also be medically stationary at claim closure. Finally, based on OAR 436-035-0005(6), the Board observed that a "direct medical sequela" is "a condition that originates or stems from an accepted condition that is clearly established medically."

Turning to the case at hand, the Board acknowledged that claimant's current attending physician had previously indicated agreement with an earlier physician's opinion that had considered claimant's condition to be medically stationary. Nevertheless, the Board noted that the attending physician had also recommended an evaluation by a pain specialist. Furthermore, because that specialist had subsequently determined that claimant suffered from RSD or a skin nerve injury that was caused by claimant's accepted ankle condition or her surgery, the Board concluded that the preponderance of the record "clearly established medically" that a "direct medical sequela" of the accepted condition was not medically stationary at claim closure. See OAR 436-035-0005(6).

In reaching its conclusion, the Board rejected the carrier's contention that the rule's "clearly established medically" requirement had not been satisfied because the specialist had ambivalently related claimant's symptoms to either RSD or a nerve injury. Reasoning that the specialist and claimant's current attending physician had attributed claimant's complaints (whatever the correct diagnosis) to her accepted ankle condition or surgical procedure for that condition, the Board found that the physicians' opinions clearly established medically the existence of a direct medical sequela from an accepted condition.

## Standards: Work Disability – Award Allowable for “Administratively Closed” Claim

*Leisl D. Schneible*, 66 Van Natta 115 (January 21, 2014). Applying ORS 656.214(1)(c)(A), (B), ORS 656.268(1)(c) and OAR 436-030-0034(1), the Board held that claimant was entitled to a work disability award for her knee condition, even though her claim had been administratively closed for her failure to seek medical treatment for more than 30 days without her attending physician's approval. In administratively closing claimant's knee claim, the carrier awarded permanent impairment for her meniscus tear, but no work disability. In doing so, the carrier stated that, because the claim had been administratively closed, no work disability was allowed. After an Order on Reconsideration found that claimant had not been released to her regular work by her attending physician and awarded work disability, the carrier requested a hearing, seeking reinstatement of its Notice of Closure.

The Board rejected the carrier's request. Citing ORS 656.268(1)(c), OAR 436-030-0020(1)(c), and OAR 436-030-0034(1), the Board stated that a carrier must close a claim when a worker is not medically stationary and has failed to seek medical treatment for more than 30 days without approval of the attending physician for reasons within the worker's control. Relying on OAR 436-030-0034(1)(d), the Board noted that, in closing such a claim, one of the carrier's requirements was to "[r]ate all permanent disability apparent in the record (e.g., irreversible findings) at the time of claim closure."

Turning to the case at hand, the Board acknowledged the carrier's assertion that the aforementioned administrative rule refers to "irreversible findings" and not to "permanent work restrictions." Nevertheless, the Board disagreed with the carrier's contention that the implication from the rule was that work disability was not allowed in an "administratively closed" claim. Reasoning that "e.g." means "for example" (*Webster's Third New Int'l Dictionary* 801 (unabridged ed 2002)), the Board considered the reference in the rule to "e.g., irreversible findings" to represent an example of the permanent disability to be rated in an "administratively closed" claim and, as such, did not exclude other ratable permanent disability findings.

Furthermore, citing ORS 656.214(1)(c)(A), (B), the Board stated that "permanent partial disability" encompasses both permanent impairment or permanent impairment and *work disability* resulting from the compensable injury or occupational disease. Likewise, relying on ORS 656.214(2)(b), the Board noted that if the worker has not been released to regular work by the attending physician or has not returned to regular work at the "at-injury" job, the permanent disability award shall be for impairment *and* work disability.

Based on the aforementioned statutes, the Board determined that the term "permanent partial disability" includes both permanent impairment and work disability resulting from the compensable injury. Consequently, the Board concluded that work disability must be rated when a claim is "administratively closed" pursuant to ORS 656.268(1)(c) and OAR 436-030-0034(1). Because it was uncontested that claimant was not released to return to her regular work by her attending physician, the Board held that she was entitled to a work disability award.

*Because "permanent partial disability" includes both permanent impairment and work disability resulting from the compensable injury, the Board concluded that work disability must be evaluated when a claim is "administratively closed."*

TTD: Rate - "Extended Gap" -  
 "060-0025(5)(a)(A)" - "Length" /  
 "Circumstances of Employment  
 Relationship" / "Contemplation When  
 Relationship Formed" - "Paving" Job -  
 "Winter Season Layoff" Period

*Erica L. Tallerday*, 66 Van Natta 106 (January 16, 2014). Applying OAR 436-060-0025(5)(a)(A), in calculating claimant's average weekly wage (AWW) for purposes of determining the rate of her temporary total disability (TTD) benefits, the Board held that claimant's 10-week "lay-off" period from her job for a paving company (during the winter season) constituted an "extended gap" in her employment and, as such, should be excluded from the calculation of her AWW and TTD rate. Before her compensable injury, claimant worked seven years as a laborer on an asphalt paving crew. During that time, she had experienced three gaps in her employment, ranging from 23 weeks, 12 weeks, and 10 weeks. The first two gaps had occurred several years before her compensable injury, while the 10-week gap had taken place within one year of her injury. When the carrier included that 10-week period in the calculation of her AWW/TTD rate, claimant objected. Contending that the 10-week period

constituted an “extended gap,” she asserted that this gap should be excluded from her AWW/TTD rate calculation and that her rate should be based on the 42 weeks of her actual employment during the 52 weeks preceding her compensable injury.

The Board agreed with claimant’s contention. Citing OAR 436-060-0025(5)(a)(A), the Board stated that, in calculating a claimant’s average weekly earnings for purposes of determining a TTD rate, the carrier must use the 52 weeks preceding the date of the compensable injury, unless “extended gaps” exist. Referring to *SAIF v. Frias*, 169 Or App 345, 350 (2000), the Board further noted that, under the aforementioned rule, “gaps” must be considered on a “claim-by-claim basis,” and must be made in light of its length and of the circumstances of the individual employment relationship itself, including whether the parties contemplated that such gaps would occur when they formed the relationship.

Turning to the case at hand, the Board acknowledged that a job posting characterized claimant’s job as “seasonal” from “May to November.” Nonetheless, the Board gave little probative weight to the posting because from the outset of claimant’s employment she had worked in all seasons of the year, often during the winter and spring. Moreover, the Board noted that claimant’s testimony that there was little “downtime” at her job was not refuted by any employer witness.

Based on such evidence, the Board was not persuaded that a 10-week gap in employment was contemplated when claimant was hired. Nevertheless, the Board recognized that its determination of whether a gap was extended must also be “made in light of its length and of the circumstances of the individual employment relationship itself.” See OAR 436-060-0025(5)(a)(A).

Addressing that aspect of the rule, the Board found that, during her seven years of employment there were only two other periods that exceeded the 10-week period in question. Under such circumstances, the Board concluded that the 10-week gap constituted an “extended gap” and, as such, must be excluded from the calculation of claimant’s AWW/TTD rate.

Member Langer dissented. Noting that claimant’s job was identified as “seasonal” and that an employer witness had testified that it was standard procedure to advise new employees of seasonal adjustments due to weather conditions, Langer was persuaded that extended gaps in claimant’s employment were contemplated at the time of her hiring. Furthermore, reasoning that claimant’s current 10-week winter layoff essentially mirrored similar winter layoffs in the previous two years of her employment and observing that an employer witness had explained that claimant’s job had changed several years after her hiring due to economic adjustments, Member Langer asserted that, considering the nature of the employer’s construction business and the economic environment, the 10-week layoff did not constitute an “extended gap” and, as such, the carrier had properly calculated claimant’s AWW/TTD rate.

*Because a 10-week gap in employment was not contemplated when claimant was hired and because there were only two such gaps in her 7-year relationship with her employer, the Board concluded that the 10-week period constituted an “extended gap” and, as such, was excluded from the calculation of her TTD rate.*

*A dissenting opinion reasoned that because there were similar layoffs in the two years preceding claimant’s most recent layoff, the 10-week period did not constitute an “extended gap.”*

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**APPELLATE DECISIONS  
UPDATE**

Course & Scope: Working at Home -  
Tripping Over Dog Walking to Garage to  
Perform Work Task - “Course Of”

Employment

*J. C. Penney Co., Inc. v. Sandberg*, \_\_\_ Or App \_\_\_ (January 23, 2014). The court affirmed without opinion the Board’s order in *Mary S. Sandberg*, 64 Van Natta 238 (2012), previously noted 31 NCN 2, which held that claimant’s injury, which arose when she tripped over her dog while walking from her home to her garage to perform a work task, occurred in the course of her employment.

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**APPELLATE DECISIONS  
COURT OF APPEALS**

Combined Condition: Invalid “Ceases”

Denial - “262(6)(c)” - Combined Condition

Must First Be Accepted

*TriMet, Inc. v. Davis*, \_\_\_ Or App \_\_\_ (January 23, 2014). The court affirmed, *per curiam*, the Board’s order in *Debra Davis*, 64 Van Natta 656 (2012), which held that a carrier’s “ceases” denial of a combined condition under ORS 656.262(6)(c) was procedurally invalid because the combined condition had not been previously accepted. The court cited *TriMet v. Wilkinson*, 257 Or App 80 (2013).

Standards: Work Disability - Release to  
Return to Regular Work - “DOT” Code  
 (“Strength” Requirement) Should Not  
Have Been Considered

*Central Oregon Intergovernmental Council-COIC v. Albert*, \_\_\_ Or App \_\_\_ (January 23, 2014). The court reversed the Board’s order in *Tyrel Albert*, 63 Van Natta 2327 (2011), which held that claimant was entitled to a work disability award for his knee condition based on its finding that his attending physician had not released him to return to his regular work. In reaching its conclusion, the Board had considered the Dictionary of Occupational Title (DOT) Code for a forestry worker, which coincided with his “at injury” job. Noting that the strength requirement for such a position was “heavy,” the Board discounted the employer’s regular job analysis for claimant’s “at-injury” job, which had listed the physical requirements of the position as less than “heavy.” Consequently, the Board determined that claimant’s attending physician’s concurrence with a

“physical capacity evaluation” (based on the job analysis) did not establish that the physician had released claimant to his regular work, particularly when the physician had subsequently indicated that he was not released to regular work.

On appeal, the carrier contended that the Board had erroneously relied on the DOT codes in determining whether claimant had been released to his regular work. The court agreed with the carrier’s contention.

Citing *SAIF v. Ramos*, 252 Or App 361, 363 (2012), the court stated that it reviews the Board’s decision for substantial evidence and errors of law, and to determine whether the Board’s analysis comports with substantial reason. Applying those principles to the case at hand, the court concluded that the Board had erred in using the DOT code as support for a determination that claimant had not been released to his regular work by his attending physician.

Based on its review of the record, the court found that the Order on Reconsideration (issued by the Appellate Review Unit (ARU)) had applied the DOT code for purposes of calculating claimant’s work disability, *after* it had determined that claimant was entitled to work disability benefits because his attending physician had not released him to his regular work. In contrast, the court noted that the Board, without any argument from either party on the subject, had used the DOT code as support for answering the predicate question of whether claimant’s attending physician had released him to his regular work.

Reasoning that ARU’s use of the DOT code did not constitute *evidence* of claimant’s actual “at-injury” job duties, the court concluded that the Board should have determined whether claimant had been released to his “at-injury” job based on evidence in the record; e.g., medical records describing the work he was performing when he was injured, his own description of his work history, the employer’s “Regular Duty Job Analysis,” and the evidence regarding claimant’s “post-injury” capacity. Consequently, the court remanded for the Board to perform that determination.

In reaching its conclusion, the court emphasized that it was not holding that DOT codes could never be helpful in assessing whether a worker had been released to regular work. To the contrary, the court acknowledged the possibility that, in a particular case, a party’s or fact finder’s identification of a DOT code as reflecting a worker’s job duties could be based on historical facts not otherwise reflected in the record of a case and, as such, could arguably itself serve as evidence of the worker’s actual duties. However, in the present case, the court found nothing to suggest that the ARU based its choice of DOT code on anything other than the same documentary evidence in the record before the Board. Accordingly, the court reasoned that ARU’s choice of the “forestry worker” DOT code added nothing to the evidence about the nature of claimant’s “at-injury” job duties.

*In determining whether claimant had been released to his “at-injury” job, the court concluded that the Board should have based its determination on the evidence in the record, rather than on a DOT code which is used for purposes of calculating a work disability award after it is determined that a claimant has not returned, or been released to return, to regular work.*