Tech Update - Portal Enhancements Coming Soon

- by Greig Lowell

The WCB Portal will be adding a new feature this spring. Attorney firms will be able to announce their representation with an electronic “File an Appearance” and also be able to file their “Response to Issues” electronically. As part of the “File an Appearance” feature, users will also be able to notify WCB of a change in the assigned attorney through the “Update the Attorney of Record” feature.

The program is in the testing phase with the launch scheduled for the end of March, 2017. To introduce the program to stakeholders, WCB hosted “open house” programs in Salem and Portland in January. Turnout was excellent in both locations, with representatives from more than a dozen attorney firms attending.

Attendees were shown how to complete those filings, where to view them in their portal accounts, and how to provide copies to opposing parties via the portal e-mail system. The general reaction from attorney firms was that the technology looked easy to use, and would save time and expense in their daily work.

The project involved representatives from WCB’s Administrative Services Division, Hearings Division, and DCBS Information Technology and Research.

Announcements on the launch and training opportunities will be forthcoming in early March. Contact us at portal.wcb@Oregon.gov for more information, or call Greig Lowell at (503)934-0151.

Administrative Staff Conference Scheduled for April 19

WCB will be hosting an Administrative Staff Conference on April 19, 2017 at the Holiday Inn – South Wilsonville.

This program is specifically designed for administrative staff, such as paralegals, legal assistants and other support staff. It will feature instruction and training on all WCB-related activities, including Hearings, Docketing, Board Review, Briefs, Own Motion, and the Portal.
CASE NOTES (CONT.)

Own Motion: “NOC” Procedurally Invalid - “AP” Impairment Findings Not Sought - Carrier’s Claim Closure Unreasonable

Penalty: “268(5)(f)” - “NOC” “Work Disability” Award (Based on “BFC” for One “DOT” Code) Not Unreasonable - Despite Recon Order’s “BFC” Value Based on “Combined” DOT Codes

APPELLATE DECISIONS

Update
TTD (Rate): “210”/“080-0040” - Unpaid Intern/Partial Commission For “NCE” - Rate Based on “Assumed Wage” on Which Premium Would Have Been Calculated

Claim Filing: “Good Cause” For Untimely Claim Filing - “265(4)(c)” - “Reasonable Worker” Standard

Juan Estrada, 69 Van Natta 71 (January 17, 2017). Applying ORS 656.265(4)(c), on remand from the Court of Appeals, Fed. Express Corp. v. Estrada, 275 Or App 400 (2015), the Board held that claimant had not established “good cause” for his untimely report of his work accident to his employer because a “reasonable worker” would have concluded that workers’ compensation liability was reasonably possible and that it was appropriate to report the accident to his employer within the statutory 90-day period. Claimant, a delivery truck driver, felt “a weird pull” while he was loading a heavy item, but did not report a work injury because he thought it was “just soreness.” Over the ensuing months, his symptoms continued and increased, causing increased difficulty in working. He eventually sought treatment more than four months after the work incident, which resulted in a hernia diagnosis. Claimant reported the work injury to his employer more than five months after the work incident. The carrier contended that claimant’s injury report was untimely, but claimant contended that he had “good cause” for his untimely report.

The Board agreed with the carrier’s contention. Citing ORS 656.265(1)(a) and (4)(c), the Board stated that claimant was required to provide notice of an “accident resulting in an injury or death” not more than 90 days after the accident, but that untimely notice would not bar a claim if the notice was given within one year of the accident and claimant had “good cause” for the untimely notice. The Board noted that “good cause” for untimely notice may exist for a variety of different reasons. Referring to John S. Smith, 64 Van Natta 340 (2012), and Corey A. Otterson, 63 Van Natta 156 (2011), the Board observed that the decisions were consistent with the rationale that “good cause” for untimely notice exists if the worker did not know of an “accident resulting in an injury or death” to report. Analogizing to the “reasonable employer” standard under Argonaut Ins. Co. v. Mock, 95 Or App 1, 5, rev den, 308 Or 79 (1989), for analyzing “employer knowledge” issues under ORS 656.265(4)(a), the Board reasoned that when analyzing “good cause” under ORS 656.265(4)(c), it would apply a “reasonable worker” standard (i.e., whether the worker knew of enough facts to lead a reasonable worker to conclude that workers’ compensation liability was a reasonable possibility and that notice to the employer was appropriate).

Sought treatment four months after work incident.

Enough facts to conclude workers’ compensation was a reasonable possibility.
The Board recognized that a worker’s knowledge of the “accident resulting in an injury or death” may be affected by the significance of the accident or symptoms. However, relying on Michael D. Chilcote, 64 Van Natta 766 (2012), the Board reiterated that if a worker knew of an “accident resulting in an injury or death,” “good cause” for untimely notice would not exist merely because the worker did not consider the accident or injury “significant.” Likewise, the Board reasoned that an “injury,” for workers’ compensation purposes, requires medical treatment or results in disability or death, but that “good cause” does not exist merely because a worker chooses to forego professional medical treatment and “work through” a known injury.

Turning to the case at hand, the Board acknowledged claimant’s testimony that he initially was not aware that he was injured. Nevertheless, the Board found that claimant was aware of symptoms resulting from a work accident, and that his symptoms persisted and increased. Reasoning that claimant had not established that he did not understand (before the expiration of the 90-day reporting period) that his accident had resulted in an injury, the Board concluded that he did not have “good cause” for the untimely filing of his injury claim.

Member Weddell dissented. Weddell agreed with the “reasonable worker” standard announced in the majority’s opinion, but was persuaded that claimant initially believed he was uninjured and did not appreciate the possibility of a work-related injury within the 90-day reporting period. Under such circumstances, Member Weddell concluded that claimant had “good cause” for the untimely notice of his work accident.

Claim Filing: “265(4)”/“310” - Notice of Work Injury to Employer via “Lead Worker” (Supervisory Capacity) - Presumption of “Timely/Sufficient” Notice Not Rebutted

Alan B. Dent, 69 Van Natta 192 (January 27, 2017). Applying ORS 656.310 and ORS 656.265(1)(a), (4), the Board found that the carrier had not persuasively rebutted the presumption that claimant had provided timely notice of his injury claim for inguinal hernias because the record established that he had notified his lead worker (who he considered to be his supervisor) of the work incident the day after it had occurred. While performing his work duties, claimant lifted a heavy plastic roll and felt “something pull” in his groin area. He reported his injury the next day to his lead worker, who he considered his supervisor. The lead worker promptly informed claimant’s supervisor that claimant may have injured himself. Subsequently, claimant commented to his supervisor that he was not sure if his condition was work-related. After undergoing a medical evaluation, claimant eventually completed an 801 form some eight months after the work incident. The carrier denied the claim, asserting that claimant did not give timely notice of his injury to the employer. Claimant requested a hearing, contending that the carrier had not persuasively rebutted the presumption of timely and sufficient notice under ORS 656.310(1)(a).
The Board agreed with claimant’s contention. Observing that ORS 656.265(1) requires a claimant to give the employer notice of an accident resulting in an injury within 90 days after the accident, the Board noted that a claim is not barred if notice is given within one year and the employer had knowledge of the injury within 90 days of the accident, or the worker establishes good cause for failure to give notice within 90 days of the accident. See Keller v. SAIF, 175 Or App 78, 82, rev den, 333 Or 260 (2002). Citing ORS 656.310(1)(a) and Nat’l Farmers’ Union Ins. v. Scofield, 57 Or App 23, 25, rev den, 293 Or 373 (1982), the Board observed that there is a rebuttable presumption that “[s]ufficient notice of injury was given and timely filed,” which a carrier must overcome to defeat the claim. Furthermore, referring to Colvin v. Ind. Indem., 301 Or 743, 747 (1986), the Board remarked that, for knowledge of a work injury to be imputed to an employer, the person receiving the knowledge must be in some supervisory or representative capacity. Finally, relying on Argonaut Ins. Co. v. Mock, 95 Or App 1, 5, rev den, 308 Or 79 (1989), the Board reasoned such “knowledge” of the injury should include enough facts as to lead a reasonable employer to conclude that workers’ compensation liability is a possibility and that further investigation is appropriate.

Turning to the case at hand, the Board was persuaded by claimant’s testimony that he reported his injury to his lead worker (whom he considered his supervisor) the day after the work incident. Moreover, the Board noted that the lead worker had relayed the information to claimant’s supervisor the following day. Under such circumstances, the Board concluded that the carrier had not overcome the presumption of timely and sufficient notice under ORS 656.310(1)(a).

Member Curey dissented. Reasoning that claimant’s supervisor’s version of events was more persuasive (i.e., that claimant had reported that the injury had not occurred at work, but he subsequently claimed a work-related injury when he learned that his treatment would not be covered by the Oregon Health Plan), Curey asserted that the employer neither received timely knowledge of a work-related injury nor that workers’ compensation liability was a possibility. Consequently, Member Curey contended that the carrier had provided sufficient evidence to rebut the presumption that claimant had provided timely and sufficient notice of a work injury.


Angela M. Freemont, 69 Van Natta 57 (January 12, 2017). Applying ORS 656.005(7)(a)(A), the Board found claimant’s new/omitted medical
Medication reaction accepted, burn denied.

Proper inquiry was relationship between the treatment and compensable injury, rather than weighing opinions on course of treatment.

Analysis limited to compensability, not propriety of DMSO.

condition claim for a “first degree burn” compensable because medical treatment (prescribed dimethyl sulfide (DMSO)) for a compensable wrist condition was the major contributing cause of the burn. Claimant’s attending physician prescribed DMSO with hydrocortisone. After applying the DMSO medication, claimant sought treatment for wrist symptoms and was diagnosed with a “medication reaction” and “first degree burn.” The carrier accepted the “medication reaction,” but denied the claim for a “first degree burn,” disputing both the existence of the condition and its relationship to the compensable injury. Claimant requested a hearing, contending that the condition existed and was caused, in major part, by treatment for the compensable injury.

The Board agreed with claimant’s contention. Referring to Allen v. SAIF, 279 Or App 135 (2016), and English v. Liberty Northwest Ins. Corp., 271 Or App 211 (2015), the Board stated that the “compensable injury” is defined by the work-related injury incident, not by the accepted condition. Relying on Barrett Bus. Servs. v. Hames, 130 Or App 190, 193, rev den, 320 Or 492 (1994), the Board further noted that a consequential condition has been found compensable when reasonable and necessary treatment for a compensable injury was the major contributing cause of the claimed condition.

The Board acknowledged the carrier’s argument that the DMSO treatment was not “reasonable and necessary” because different treatment was more appropriate or that DMSO was a medical treatment that was “not compensable” under OAR 436-009-0010(12)(a). Nonetheless, relying on the Hames rationale, the Board reasoned that the determination of whether the claimed consequential condition had resulted from reasonable and necessary treatment did not depend on weighing competing medical opinions regarding different courses of treatment. Instead, the Board explained that the relevant inquiry concerned the relationship between the event in question (i.e., the DMSO/hydrocortisone treatment) and the compensable injury.

The Board further observed that the standard for analyzing the compensability of a consequential condition under ORS 656.005(7)(a)(A) and the Hames holding (i.e., whether the compensable injury, including “reasonable and necessary” treatment, was the major contributing cause of the consequential condition) was outside the Director’s authority to determine the appropriateness of a medical service. Under such circumstances, the Board concluded that OAR 436-009-0010(12)(a) was not germane to determining the compensability of the claimed consequential condition.

Turning to the case at hand, the Board found that the medical evidence established that the burn existed and had been caused, in major part, by the DMSO component of the prescribed medication. Furthermore, the Board determined that the DMSO/hydrocortisone treatment was an integral part of the treatment for claimant’s compensable injury, and was therefore “reasonable and necessary” treatment. Accordingly, the Board concluded that the claimed “first degree burn” was compensable as a consequential condition.

In reaching its conclusion, the Board emphasized that its analysis was limited to analyzing the compensability of a claimed consequential condition pursuant to the Hames rationale and, as such, did not usurp the Director’s authority to determine the propriety of the “DMSO” medical service in
accordance with ORS 656.704(3)(b)(B). Nonetheless, the Board further noted that the carrier had not submitted a medical service dispute to the Director, challenging the propriety of the DMSO treatment.

Costs: “386(2)(d) - “Extraordinary Circumstances” For Costs Exceeding $1,500 - Cost Exceeded “$1,500 Threshold” Due to Specialist’s Report, Which Was Determinative in Proving Claim - Circumstances Were Beyond “Usual, Regular, or Customary”

Attorney Fee: “Cost-Related” Fee - “Waived” For Hearing Level via Claimant’s Counsel Statements, But Not “Waived” for “Appellate” Level

Kevin J. Siegrist, 69 Van Natta 92 (January 19, 2017). On reconsideration of its initial opinion, 68 Van Natta 1283 (2016), applying ORS 656.386(2)(d), the Board continued to find that claimant had established “extraordinary circumstances” justifying reimbursement of his cost bill for more than $1,500. In seeking reconsideration, the carrier contended that: (1) claimant’s cost bill was “procedurally defective” to raise the extraordinary circumstances issue; (2) the legislative history was inconsistent with a finding of “extraordinary circumstances” where the total cost bill was only $1,550; and (3) the circumstances of the case were not “extraordinary.” Claimant also sought reconsideration of the Board’s previous conclusion that he had waived an attorney fee under ORS 656.386(4) for his counsel’s services at the hearing level and on review.

The Board disagreed with the employer’s contentions. Relying on Stevenson v. Blue Cross of Oregon, 108 Or App 247 (1991), the Board declined to consider the carrier’s contention that the cost bill was “procedurally defective” because that issue had not previously been raised. After reviewing the legislative history, the Board observed that the legislature did not intend for “extraordinary circumstances” to be defined by a “dollar figure” threshold. Instead, based on the legislative history, the Board explained that it would review whether the additional expense was warranted and necessary. Consequently, the Board concluded that it would continue to evaluate whether the circumstances went beyond those that were “usual, regular, common, or customary in this forum,” rather than by examining the amount by which the cost bill exceeded $1,500.
Claimant needed specialist opinion to prove his claim.

Counsel expressly waived entitlement to a fee at hearing; but no express waiver at appellate level.

Board reiterated application of standard for rating multiple disc surgeries.

Turning to the case at hand, the Board continued to find “extraordinary circumstances.” In doing so, the Board emphasized that, in light of the opposing opinion of a highly credentialed expert, claimant would not have been able to prove his claim without obtaining, at significant cost, the specialist’s opinion that took claimant’s costs beyond the $1,500 threshold.

Addressing claimant’s attorney fee request, the Board observed that, pursuant to Drews v. EBI Cos., 310 Or 134 (1990), and Wright Schuchart Harbor v. Johnson, 133 Or App 680 (1995), a waiver is a relinquishment of a known right, plainly and unequivocally manifested. Citing Hays v. Tillamook County Gen Hosp., 160 Or App 55 (1998), the Board noted that entitlement to an attorney fee is a “natural derivative” and does not need to be separately asserted. Nevertheless, citing Katrina Miller, 60 Van Natta 1630 (2008), the Board explained that a claimant may waive the right to a specific type of attorney fee award.

Based on claimant’s counsel’s express statement at hearing regarding the entitlement to an attorney fee, the Board found that claimant had waived the right to an assessed fee for services at the hearing level. Nevertheless, reasoning that claimant’s counsel’s statement was limited to the hearing level and did not address the right to an attorney fee for subsequent services on Board review/reconsideration, the Board granted an attorney fee award for claimant’s counsel’s services at the appellate level.

Extent: Permanent Impairment - Rating Lumbar Surgeries - Additional Disc/Vertebrae Treated - “035-0350(2)”

Kathryn C. Rodgers, 69 Van Natta 155 (January 25, 2017). Applying OAR 436-035-0350(2), in rating the extent of claimant’s permanent impairment attributable to a compensable low back condition, the Board held that she was entitled to an additional 1 percent impairment value for each lumbar disc/vertebrae treated in surgeries subsequent to her first lumbar surgery. An Own Motion Notice of Closure awarded claimant additional permanent impairment for her “new/omitted medical condition” claim for a low back condition. Claimant requested Board review, seeking an increased permanent disability award. The parties agreed that claimant was entitled to 9 percent impairment for her first lumbar surgery. See OAR 436-035-0350(2). However, the carrier contended that her two subsequent surgeries entitled her to 1 percent impairment for either the disc or the vertebra treated, but not both. In response, claimant asserted that she was entitled to an additional 1 percent impairment for each disc or vertebra treated.

The Board agreed with claimant’s position. Citing OAR 436-035-0350(2), the Board stated that the first surgical procedure “[i]nvolving 1 disc, 1 or 2 vertebrae, or any combination” receives 9 percent impairment. Under that rule, the Board noted that, if the first surgical procedure also includes “[a]dditional disc(s) or vertebra treated within the same region/body part,” the calculation must “[a]dd 1% for each additional disc or vertebra.” (Emphasis added). Likewise, the Board observed that, for “[s]ubsequent surgical
procedures,” the calculation must “[a]dd 1% for each disc or vertebrae treated.” (Emphasis added). Relying on David A. Dube, 65 Van Natta 358, 366 (2013) and Robert C. Sharp, 64 Van Natta 2369, 2374-75 (2012) (among other decisions), the Board reiterated that it had consistently applied OAR 436-035-0350(2) in the aforementioned manner.

Turning to the case at hand, the Board found that claimant was entitled to impairment values for her three lumbar surgeries, which qualified as “irreversible findings” under OAR 436-035-0005(7)(i). Applying OAR 436-035-0350(2), the Board found that: (1) the first surgery, a discectomy at L4-5, received a value of 9 percent impairment; (2) the second surgery treated one disc and two vertebrae and received a value of 3 percent; and (3) the third surgery treated four vertebrae and received a value of 4 percent. The Board then added these values for a total surgery impairment value of 16 percent.

The remaining impairment values and the social-vocational value were undisputed. Therefore, after application of the limitation in ORS 656.278(2)(d), claimant was entitled to an additional 19 percent unscheduled PPD, less the 16 percent unscheduled PPD awarded by the Notice of Closure.

Occupational Disease: No “Preexisting Condition”/“Mere Susceptibility” - Corkum “Active/Passive Contribution” Rationale Applied to OD Claim

David Dunn, 68 Van Natta 14 (January 3, 2017). Applying ORS 656.005(24)(c), in analyzing the compensability of an occupational disease claim under ORS 656.802(2), the Board concluded that a condition that merely rendered the worker more susceptible to the occupational disease was not a "preexisting condition" or a "cause" to be weighed in the determination of the major contributing cause of the claimed condition. After claimant sought medical treatment for his foot pain, he filed an occupational disease claim for his foot condition. Medical examinations detected an unfused fifth metatarsal apophysis, which was a congenital condition that preceded the onset of his fifth metatarsal apophysitis condition. The carrier denied the claim, contending that claimant’s work activities were not the major contributing cause of a pathological worsening of his preexisting foot condition. Claimant requested a hearing, asserting that his unfused apophysis was not a “preexisting condition” (but, instead was a mere susceptibility, not a cause) because it was a congenital condition that had not actively contributed to his claimed apophysitis. Rather, claimant argued that his walking at work was the major contributing cause of his apophysitis.

The Board agreed with claimant’s contention. Citing Liberty Northwest Ins. Corp. v. Spurgeon, 109 Or App 566 (1991), rev den, 313 Or 210 (1992), and Multnomah County v. Obie, 207 Or App 482 (2006), the Board observed that “predispositions” and “susceptibilities” are not considered “causes” to be weighed in determining the major contributing cause of an occupational disease. Relying on Murdoch v. SAIF, 233 Or App 144 (2008), rev den, 346 Or 361 (2009), the Board noted that the court that, in analyzing an occupational disease
Board declined to depart from case precedent applying “005(24)” when analyzing “O.D.” claims.

Under ORS 656.802(2), the court had applied ORS 656.005(24)(c), which provides that a condition does not contribute to disability or need for treatment if it merely renders the worker more susceptible to injury.

The Board acknowledged that the carrier disputed the Spurgeon, Obie, and Murdoch rationale in presenting its argument that all contributing causes (even those that are not “preexisting conditions” under ORS 656.005(24)) must be considered in analyzing the compensability of an occupational disease claim. Nevertheless, reasoning that the Murdoch decision had expressly applied the Obie court’s rationale (which had addressed the question of whether a predisposition was a “preexisting condition” in the context of an occupational disease claim) and observing that the Murdoch holding had been applied in Natalia Gonzalez-Perez, 67 Van Natta 1981 (2015), the Board declined the carrier’s invitation to depart from those authorities.

Furthermore, referring to Corkum v. Bi-Mart Corp., 271 Or App 411 (2015), the Board observed that the court had explained that a condition merely renders a worker more susceptible to injury if it increases the likelihood that the affected body part will be injured, but does not “actively contribute to damaging the body part.” Citing Gonzalez-Perez, the Board noted that it had applied the Corkum rationale in analyzing the compensability of an occupational disease claim.

Turning to the case at hand, the Board was persuaded by the medical opinions that the unfused apophysis did not actively contribute to claimant’s apophysitis. Consequently, the Board determined that the unfused apophysis constituted a “mere susceptibility” and not a “preexisting condition” under ORS 656.005(24) and, as such, could not be considered a “cause” in the determination of the major contributing cause of the apophysitis condition. Under such circumstances, the Board concluded that the active cause of claimant’s apophysitis (i.e., walking at work) was the major contributing cause of his occupational disease and, as such, found the claim compensable.

Own Motion: “NOC” Procedurally Invalid - “AP” Impairment Findings Not Sought - Carrier’s Claim Closure Unreasonable

Gustavo F. Avila, 69 Van Natta 1 (January 3, 2017). In an Own Motion order, the Board held that a Notice of Closure was procedurally invalid because the carrier had not sought information from the attending physician to rate claimant’s permanent impairment. Before closing claimant’s new/omitted medical condition claim, the carrier attempted to obtain concurrences regarding an examining physician’s findings of no impairment from two non-attending physicians, neither of whom responded. Thereafter, the carrier closed the claim without any permanent disability award. On review, claimant contended that the closure notice was invalid because there was insufficient information to rate his permanent impairment.

The Board agreed with claimant’s contention. Citing Charles D. Leffler, 67 Van Natta 1997 (2015), the Board noted that an Own Motion Notice of Closure may be invalid when the carrier does not obtain the attending
physician’s findings of permanent impairment or the attending physician’s ratification of such impairment findings from another provider. Relying on Dwayne L. Minner, 67 Van Natta 2006 (2015), the Board noted that an Own Motion Notice of Closure was not premature when the carrier unsuccessfu

s determined identity of attending physician. Turning to the case at hand, the Board considered the present situation more akin to Leffler. First, the Board noted that, in rescinding a previous closure notice, it had determined that another physician was claimant’s attending physician at claim closure. Second, based on its review of the record, the Board found that the previously determined “attending physician” retained that status at the time of the current closure notice.

Notwithstanding these determinations, the Board observed that the carrier had not contacted the attending physician to ratify impairment findings from a non-attending physician. Instead, the Board noted that the carrier had provided the impairment findings to two “non-attending physicians,” neither of whom had responded to the carrier’s submission. Under such circumstances, the Board rescinded the closure notice as procedurally invalid because no “attending physician-ratified” impairment findings had either been sought or submitted before claim closure.

Finally, the Board assessed penalties and attorney fees under ORS 656.262(11)(a). Citing Ronald E. Sullivan, 61 Van Natta 108, 113-14 (2009), Howard D. Smith, 57 Van Natta 1817, 1827-30 (2005), and David J. Swanson, 57 Van Natta 885, 887 (2005), the Board found that the carrier did not have a legitimate doubt regarding its liability. Specifically, citing its previous decision, Gustavo Avila, 68 Van Natta 294, the Board noted that it had set aside an earlier closure notice based on a lack of permanent impairment findings from claimant’s attending physician. Reasoning that the previously identified attending physician remained claimant’s attending physician for this claim closure, the Board determined that the carrier’s failure to seek input from that physician regarding claimant’s permanent impairment findings before closing the claim was unreasonable.

Penalty: “268(5)(f)” - “NOC” “Work Disability” Award (Based on “BFC” for One “DOT” Code) Not Unreasonable - Despite Recon Order’s “BFC” Value Based on “Combined” DOT Codes

Phillip A. Casciato, 69 Van Natta 133 (January 24, 2017). On reconsideration of its initial opinion, 68 Van Natta 1895 (2016), the Board adhered to its earlier decision that a carrier’s calculation of claimant’s base functional capacity (BFC) value (based on one “DOT” code, with a “medium” value) in determining his work disability award in a Notice of Closure (NOC)
ARU applied combined DOT codes.

Carrier's use of a single DOT code not unreasonable.

was not unreasonable, even though an Order on Reconsideration subsequently increased his work disability award based on a “heavy” BFC value (for “combined” DOT codes). In issuing its NOC, after considering claimant’s job description and his affidavit), the carrier determined that claimant’s “at-injury” job was a crane operator, which had a “medium” BFC value based on the DOT code. After claimant requested reconsideration, the Appellate Review Unit (ARU) increased his work disability award based on a “heavy” BFC value, which it calculated from “combined” DOT codes for the crane operator position, as well as for an iron worker. Claimant requested a hearing, contending that the NOC “work disability” award (which used a “medium” BFC value) was unreasonable and, as such, he was entitled to a penalty under ORS 656.268(5)(f).

The Board disagreed with claimant’s contention. Citing OAR 436-035-0012(9)(a), the Board stated that the strength category for an “at-injury” job is determined by the category assigned in the DOT, a specific job analysis, or a job description agreed upon by the parties. Relying on Charles L. Chase, 67 Van Natta 1205, 1207 (2015), aff'd without opinion, 282 Or App 369 (2016), the Board reiterated that a claimant’s affidavit may also be considered, but only for purposes of corroborative evidence of either a DOT description or a specific job analysis, or for determining what DOT description applies, or whether a DOT description or specific job analysis is more accurate.

Turning to the case at hand, the Board acknowledged that claimant’s affidavit challenged his employer’s “at-injury” job description by asserting that the physical demands of the job exceeded that of a crane operator. Furthermore, the Board recognized that ARU had ultimately determined that a “combined” DOT code of the crane operator and iron worker position was more appropriate (which resulted in a “heavy” BFC value and an increased “work disability” award). Nonetheless, after considering the duties of the DOT descriptions for the crane operator and iron worker positions, the Board did not consider the carrier’s conclusion that claimant’s “at-injury” job more closely resembled the description for a crane operator position under the DOT code to be unreasonable. Consequently, the Board concluded that a penalty under ORS 656.268(5)(f) was not warranted.

\[ \text{APPELLATE DECISIONS UPDATE} \]

TTD (Rate): “210”/“080-0040” - Unpaid Intern/Partial Commission For “NCE” - Rate Based on “Assumed Wage” on Which Premium Would Have Been Calculated

Rehfeld v. Sedgwick Claims Management Services, 283 Or App 2888 (January 5, 2017). Analyzing ORS 656.210(1), ORS 656.054(1), OAR 436-060-0025(5)(i), (j), and OAR 436-080-0040, the court reversed the Board’s order in Ashley A. Rehfeld, 66 Van Natta 1102, on recon, 66 Van Natta 1198 (2014), previously noted 33 NCN 6:11, which held that the rate of claimant’s temporary disability (TTD) benefits should be based on the statutory minimum of $50 per week because her average weekly wage (AWW) could not
No statutory support for claimant’s use of “minimum wage” when calculating AWW.

Court also disagreed with Board’s determination of $50/week.

be determined because she was an unpaid intern for a noncomplying employer. In reaching its conclusion, the Board had rejected claimant’s contention that her AWW should be calculated based on the state’s legal minimum wage.

Although agreeing with the Board’s determination that the state’s minimum wage did not provide the basis for claimant’s TTD rate, the court concluded that the TTD rate should not be based on $50 per week. Citing OAR 436-060-0025(5) (which describes the method for calculating TTD benefits under ORS 656.210 for workers who are “employed with unscheduled, irregular or no earnings”), the court stated that TTD benefits for covered workers with no wage earnings must be computed on the same assumed wage as that upon which the employer’s premium is based (subsection (i)) or, if the worker is paid by commission, on the assumed wage on which the premium is based (subsection (j)). Relying on OAR 436-080-0040, the court noted that, in determining the civil penalty assessed against a noncomplying employer, the Workers’ Compensation Division (WCD) is required to calculate the amount of “premium the employer would have paid during the noncomplying period if insurance had been provided.”

Turning to the case at hand, the court reasoned that neither subsection of OAR 436-060-0025(5) expressly applied to claimant’s circumstances because, as a noncomplying employer, her employer did not have an “assumed wage” at the time of her injury. Likewise, after reviewing ORS chapters 656 and 653, the court found no textual support for claimant’s contention that, in the absence of an agreement by claimant’s employer to pay wages, the statutory minimum wage applied to the calculation of her TTD benefits.

Nonetheless, the court disagreed with the Board’s determination of a TTD rate of $50 per week under ORS 656.210(1). Referring to ORS 656.054(1), the court noted that “[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 this chapter.” Furthermore, relying on OAR 436-060-0025(i) and (j), the court observed that, had the noncomplying employer complied with the law, claimant’s TTD benefits would have been calculated using the “assumed wage” on which the employer’s premium would have been based.

Citing OAR 436-080-0040, the court reiterated that WCD was mandated to assess a civil penalty against a noncomplying employer based on the premium that would have been paid during the noncomplying period if insurance had been provided. Thus, in the absence of insurance premiums actually paid by her employer, the court concluded that claimant’s TTD benefits should be calculated based on the assumed wage on which the employer’s premium would have been based had it provided insurance. Consequently, the court remanded for reconsideration of claimant’s TTD benefits.