
In the Matter of the Compensation of
CLAUDE M. JONES, Claimant
WCB Case No. 01-01518
ORDER ON REVIEW (REMANDING)
Kryger Et Al, Claimant Attorneys
Sather Et Al, Defense Attorneys

Reviewing Panel: Members Biehl and Lowell.

Claimant requests review of that portion of Administrative Law Judge (ALJ) Fulsher's order that upheld the insurer's October 24, 2000 denial of claimant's injury claim for a low back condition. On review, the issue is the procedural validity of the insurer's October 24, 2000 denial. We vacate and remand.

FINDINGS OF FACT

We adopt the ALJ's Findings of Fact.

CONCLUSIONS OF LAW AND OPINION

On August 13, 2000, claimant filed a claim for an injury to his back while at work on July 19, 2000. On August 31, 2000, the insurer mailed claimant a questionnaire and requested that he return it within two weeks. Claimant did not comply with the insurer's request. The insurer also had difficulty obtaining records from claimant's medical providers. The insurer then denied claimant's claim on October 24, 2000, for the reason that "you [claimant] and/or your medical providers, are unwilling to cooperate in our investigation of your claimed condition, and that we are therefore unable to investigate your claim for benefits." (Ex. 19).

On February 22, 2001, claimant requested a hearing alleging a *de facto* denial. At hearing, claimant contended that the insurer's denial was a "noncooperation" denial and was "premature" because the insurer had not first requested suspension of benefits by the Director (through the Workers' Compensation Division (WCD)) as required by ORS 656.262(15). The parties stipulated that the insurer did not request suspension of benefits through WCD before issuing its denial. Claimant also stipulated that, if the insurer's denial was valid, then his request for hearing was untimely filed.

The ALJ upheld the insurer's denial, reasoning that ORS 656.262(15) did not foreclose other methods of issuing a denial, and that the insurer's denial otherwise met the requirements of ORS 656.262(6) and OAR 438-005-0055.

On review, claimant renews his argument that the insurer's denial was invalid. We agree.

ORS 656.262(15) provides, in pertinent part:

“If the director finds that a worker fails to reasonably cooperate with an investigation involving an initial claim to establish a compensable injury * * *, the director shall suspend all or part of the payment of compensation after notice to the worker. If the worker does not cooperate for an additional 30 days after the notice, the insurer or self-insured employer may deny the claim because of the worker's failure to cooperate. The obligation of the insurer or self-insured employer to accept or deny the claim within 90 days is suspended during the time of the worker's noncooperation.”

In addition, OAR 436-060-0135(8) provides:

“If the worker has not documented that the failure to cooperate was reasonable, the Division will issue an order suspending all or part of the payment of compensation to the worker. The suspension will be effective the fifth working day after notice is provided by the Division as required by section (7) of this rule. The suspension of compensation shall remain in effect until the worker cooperates with the investigation. If the worker makes no effort to reinstate compensation within 30 days of the date of the notice, the insurer may deny the claim.”

Our task in interpreting a statute is to discern the intent of the legislature. *PGE v. Bureau of Labor and Industries*, 317 Or 606 (1993). At the first level of analysis, we examine both the text and context of the statute. 317 Or at 610. If the legislative intent is not clear from that inquiry, we then examine the legislative history or other extrinsic aids. 310 Or at 611-612.

The plain language of the statute allows the carrier to issue a “noncooperation” denial only “*if* the worker does not cooperate for an additional 30 days after the [suspension] notice.” ORS 656.262(15) (emphasis added). Similarly, the administrative rule only allows a carrier to issue such a denial when a worker makes no effort to reinstate compensation after an order suspending compensation issued. Accordingly, if the insurer’s denial is a “noncooperation” denial, by statute and rule, the insurer was required to request suspension from the Director (WCD) before issuance of the denial.

Here, the denial expressly states that it was issued for the reason that claimant and/or his medical providers were not cooperating with the insurer’s claim investigation. (*See Ex. 19*). Accordingly, pursuant to ORS 656.262(15), the insurer was required to request Director (WCD) suspension of benefits before issuing a denial. Because the insurer did not first request suspension of benefits, its denial was procedurally invalid.

This conclusion is supported by relevant case law. In *Mark S. Lehman*, 51 Van Natta 3 (1999), we reinstated and upheld the carrier’s “noncooperation denial,” finding that the claimant had failed to cooperate with the carrier’s investigation for reasons within his control. 51 Van Natta at 4, 5. In doing so, we noted that:

“ORS 656.262(15) provides that a carrier may deny a claim for non-cooperation 30 days after the Department sends notice to the worker regarding suspension of benefits for non-cooperation. In this case, the Department’s notice was sent to claimant on August 6, 1997 and the denial issued more than 30 days later, on September 8, 1997. Under these circumstances, we do not find that SAIF failed to comply with the statutory requirements in issuing its denial or that the denial was premature or otherwise procedurally defective.” 51 Van Natta at 5 n2.

In *Lola F. Morad*, 50 Van Natta 2345 (1998), the employer contended, *inter alia*, that the claimant did not cooperate with the claim investigation process. 50 Van Natta at 2348, n1. We declined to consider the employer's argument on that point, stating that:

“[T]here is no evidence in the record that the employer provided proper notice to claimant or that the employer requested that the Director suspend payment of compensation prior to denying benefits based on claimant's alleged noncooperation. *See* ORS 656.262(15) (providing that the carrier may deny the claim based on a worker's failure to cooperate *only if* the worker does not cooperate for an additional 30 days after the Director's notice concerning cooperation).” 53 Van Natta at 2348 n1 (emphasis added).

Based on the rationale expressed in these cases, we again conclude that ORS 656.262(15) requires a carrier to first seek suspension with the Director (WCD) before issuing a “noncooperation” denial. Because the insurer did not do so in this case, the insurer's denial was procedurally invalid.

The ALJ reasoned, however, that ORS 656.262(6)(a) provides an alternative mechanism by which to deny a claim. To the contrary, ORS 656.262(6)(a) merely provides the basic requirements and time limits for the issuance of a denial. *See also* OAR 438-005-0055. The more specific requirements for a “noncooperation” denial in ORS 656.262(15) control over the general language of ORS 656.262(6)(a) pertaining to all denials. In this regard, we observe that, when one statute deals with a subject in general terms, and the other statute deals with the subject in a more particular way, the specific statute controls over the general if the two cannot be read together. *See* ORS 174.020; *State v. Guzek*, 322 Or 235, 268 (1995). Thus, where, as here, a denial is issued for the specific reason that the claimant has not cooperated with the claim investigation, then ORS 656.262(15) mandates that the carrier first request suspension by the Director.

Moreover, OAR 438-005-0055 (in addition to its “notice” requirements) provides that a denial “shall specify the factual and legal reasons for denial.” Here, the portions of the insurer's October 24, 2000 denial that satisfy this rule focus on claimant's alleged noncooperation with claim investigation. (Ex. 19). Therefore, the insurer's October 24, 2000 “noncooperation” denial, issued without first

seeking suspension by the Director, is procedurally invalid.¹

Finally, in support of the proposition that it may issue a denial under either ORS 656.262(6)(a) or ORS 656.262(15), the insurer cites our decision in *Marvin E. Lewis*, 51 Van Natta 624 (1999). In *Lewis*, we held that a carrier may issue a denial under either ORS 656.262(15) or ORS 656.325(1) when it alleges that a claimant has not cooperated with its investigation by failing to attend a scheduled insurer-arranged medical examination (IME) during an initial claim involving compensability or reopening for an aggravation. 51 Van Natta at 629. However, *Lewis* did not involve the interpretation of ORS 656.262(6)(a) in conjunction with ORS 656.262(15) and is therefore distinguishable. In *Lewis*, the insurer also went through the proper suspension process, unlike this case.

In conclusion, we find that the insurer's October 24, 2000 denial, issued in the absence of a prior "suspension" request to the Director (WCD), is set aside as procedurally invalid.²

The ALJ's order stated that the parties had agreed that, if the insurer's denial were found to be procedurally invalid, an interim order should issue and further proceedings held regarding compensability and responsibility. (*O&O* at 1, n1). On review, the parties do not dispute that characterization of the procedural posture by the ALJ. Under such circumstances, we find the record to be incompletely and insufficiently developed. *See* ORS 656.295(5). Consequently, remand to the Hearings Division is warranted.

¹ In reaching this conclusion, we note that, in other circumstances, a denial may be interpreted as both a "noncooperation" denial and an "ordinary" denial of claimant's claim "on the merits." For example, a denial may include multiple grounds, such as noncooperation, as well as a contention that a claimant's employment was not the major contributing cause of a condition. In those circumstances, if the "noncooperation" portion of a denial is procedurally invalid, and the remaining portion of the denial is procedurally valid, it is theoretically possible that a hearing could be held on that part of the denial which addresses the merits of the claimant's claim. However, here, we interpret the insurer's denial as a denial based solely on claimant's asserted noncooperation with claim investigation. (*See Ex. 19*). Consequently, the entire denial is procedurally invalid.

² Claimant's request for hearing was made more than 60 days from the insurer's denial. *See* ORS 656.319(1)(a). Nevertheless, the insurer's denial, being invalid, did not require a request for hearing within 60 days. *Knapp v. Weyerhaeuser*, 93 Or App 670, 674 (1988), *rev den* 307 Or 326 (1989) (a claimant need not request a hearing within 60 days from a denial which had "no basis in law." Therefore, the ordinary time limitation in ORS 656.319(1)(a) did not apply to foreclose the claimant's hearing request from the invalid denial).

Accordingly, we vacate the ALJ's order and remand to ALJ Fulsher for further proceedings on the merits of the claim; *i.e.*, the compensability and responsibility issues. Those proceedings shall be conducted in any manner that the ALJ determines achieves substantial justice.

ORDER

The ALJ's order dated June 13, 2001 is vacated. This matter is remanded to ALJ Fulsher for further proceedings consistent with this order. Following those proceedings, the ALJ shall issue a final, appealable order.

Entered at Salem, Oregon on May 10, 2002