



APPELLATE PROCEDURES

APPELLATE PROCEDURE

- 1. Request for Board Review:** ORS 656.289(3); 656.295(2); OAR 438-011-0005. Must be in writing and mailed to the Board, with copies to other parties and their attorneys, within 30 days of ALJ's order. Should recite name of claimant, WCB Case Number(s), identity of the party requesting review, and contain a brief statement of the reason review is requested. OAR 438-011-0005(3). Should also recite whether payment of compensation awarded by the ALJ's order will be stayed under ORS 656.313. OAR 438-011-0005(4).

Practice Tip: If a party wants an ALJ to reconsider decision, a motion for reconsideration should be filed as soon as possible. ALJ retains authority to reconsider order unless and until a request for Board review is filed. *Willie D. Brown, Jr.*, 62 Van Natta 2808 (2010); *Dennis J. Dickens*, 58 Van Natta 685 (2006).

If an ALJ issues an abatement order the same day of, or before, the filing of a request for Board review, the ALJ retains authority to proceed with reconsideration. *William I. Long*, 48 Van Natta 2193 (1996); *David L. Rolfe*, 48 Van Natta 1031 (1996). In the absence of an appeal or an abatement, ALJ's authority to reconsider expires 30 days after the mailing of the order. *McCormac v. Cottage Crafts*, 113 Or App 173 (1992).

If no motion for reconsideration is contemplated, file request for review early in the 30-day period. If the appealing party neglects to mail copies to all other parties, the Board's mailing of its computer-generated letter acknowledging the request to all parties can provide the Board with authority to proceed with its review. *Argonaut Insurance v. King*, 63 Or App 847, 852 (1983); *Tamara L. Page*, 60 Van Natta 717 (2008).

If appealing within last 7 days of 30-day appeal period, a party may wish to consider either filing through the portal, mailing request via certified mail, hand delivering to a permanently staffed Board office (Portland, Salem, Eugene, Medford), or faxing to the Board at (503)373-1684.

- 2. "Filing":** OAR 438-005-0046(1)(c). Presumed to be the date of mailing, if the request is mailed by registered or certified mail. Otherwise, "filing" presumed to be the date the request is actually received by the Board. If a request is not mailed by certified mail and is received by the Board untimely, it is presumed to be untimely unless the requesting party establishes that it was timely mailed. *See Randolph King*, 51 Van Natta 82 (1999) (affidavit from appealing party's attorney's assistant that the request was timely mailed to the Board rebutted presumption of untimely filing).

Practice Tip: Requests for Board review (and service on other parties) may also be filed by means of e-mail (OAR 438-005-0046(1)(f)) or by WCB’s portal (OAR 438-005-0046(1)(e), (g)). To file via e-mail, the address is request.wcb.@oregon.gov. The e-mail must be in the correct format/language. To file via the portal, the party’s attorney must register as a “user” at <https://portal.wcb.oregon.gov> and complete a request for Board review. OAR 438-005-0046(1)(g). Many requests for review are now being filed via the portal. The Board also allows filing, and service of documents, by fax. OAR 438-005-0046(1)(h). The Board’s fax number on Board Review is (503)373-1684.

- 3. Cross-Request for Board Review.** ORS 656.289(3). Follow the same procedures for filing a request for Board review. In addition, a cross-request must be filed within 30 days of the ALJ’s order or within 10 days of the filing of the request for Board review (whichever occurs later). The party filing the cross-request must be “aggrieved” by the ALJ’s order. *Justin D. Morris*, 64 Van Natta 1586 (2012).

Practice Tip: The Board will consider additional issues raised by a responding party in its appellate briefs, even in the absence of a timely filed “cross-request.” However, if the appealing party withdraws its request for review, the Board loses its appellate authority to consider the respondent’s issues because no timely “cross-request” would have been filed. *Eder v. Pilcher Construction*, 89 Or App 425 (1988); *Antonio Chavez*, 62 Van Natta 2368 (2010).

PROCESSING TIPS FOR BOARD REVIEW

A. Procedural Motions

1. **Extensions for Briefing Schedule**: OAR 438-011-0020(3). Requirements: Must be in writing (mailed, faxed to (503)373-1684, or e-mailed to requests.wcb@oregon.gov) to the Board before expiration of the due date for the brief, give other party's position, and provide extraordinary circumstances beyond the control of the requesting party. (Efforts are underway to allow extension requests to be filed via the portal.) Questions regarding briefs/transcripts, contact Board Review at (503)934-0103.
2. **Motion to Dismiss**: Board will respond promptly, either by order (denying or granting motion) or by letter (deferring action until review and/or asking other party to respond). Opposing party may respond to motion without Board invitation.
3. **Motion to Remand**: Board will generally defer action until completion of the briefing schedule until it reviews the merits of the case. Parties usually include their positions regarding the motion in their appellate briefs. If necessary, the Board will implement a revised or supplemental briefing schedule.
4. **Motion for Reconsideration**: Board will attempt to respond before expiration of the 30-day appeal period. To give the Board sufficient time, parties should file motions as soon as possible after Board's initial order. Board will respond promptly, either by order on reconsideration, denying reconsideration, or by abatement order. Opposing party may respond without Board invitation.

B. Settlements - Procedural Matters

1. Immediately notify the Board (503)934-0103 when parties settle their dispute, but are still drafting the agreement. The caller must also confirm the announcement in writing. Thereafter, the Board will suspend the briefing schedule or its review, pending receipt of the proposed settlement.
2. If agreement resolves disputes that are pending before the Hearings Division, the Board and/or the court, it requires approval of both an ALJ and the Board. *See* ORS 656.298(9)(a); OAR 438-009-0015(5). For expeditious processing, send that agreement to the Board's Salem office.
3. If agreement resolves a dispute pending before the court, parties can send their settlement to the Board for approval. The Board has jurisdiction to consider the settlement and to enter any orders necessary to implement the settlement. ORS 656.298(9); *Rebecca E. Seelye*, 60 Van Natta 332 (2008). If the settlement

disposes of all issues pending before the appellate court, the court may dismiss the petition for judicial review. If the settlement only partially disposes of the pending issues, the appellate court may limit its review to the unresolved issues.

C. Address Changes/Attorney Resignations

1. Announcements concerning changes in parties' or their attorneys' addresses, notification regarding an attorney's resignation, or a party's change of representation should be promptly provided in writing to the Board Review Division at its Salem office. These announcements should be included in a separate letter from a request for review or an appellate brief.

FREQUENTLY ASKED QUESTIONS

1. How do I request Board review on the last day?

You can hand-deliver your written request to any of WCB's staffed offices. The addresses for WCB's staffed offices are:

Salem: 2601 25th St. SE, Ste. 150
Portland: 16760 SW Upper Boones Ferry Rd., Ste. 220
Eugene: 1140 Willagillespie Rd., Ste. 38
Medford: 115 W Stewart Ave., Ste. 102

You can also fax your request to (503)373-1684, e-mail your request to request.wcb@oregon.gov, or file it via the portal.

2. How long will it take for the Board to review my case?

Except in extraordinary circumstances, Board review shall be scheduled for a date not later than 90 days after it receives the request for review. After the Board conducts its review and completes its research/deliberations and prepares its order, the Board will issue its decision within 30 days.

3. What factors have an effect on the Board's review?

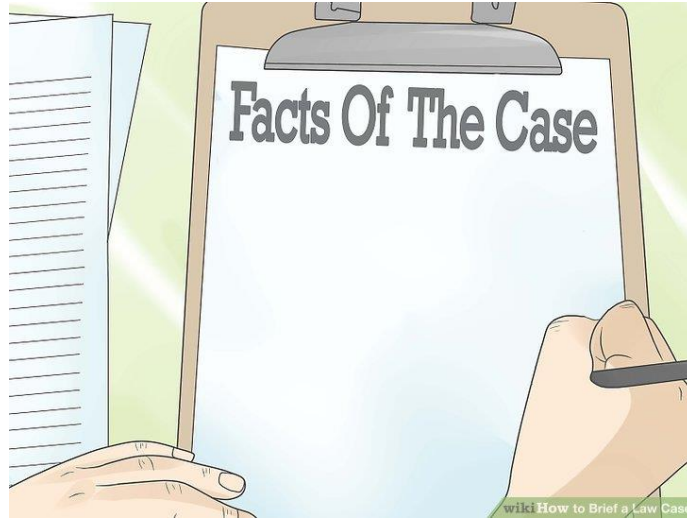
Whether the parties request extensions of the briefing schedule, whether procedural motions were raised, the complexity of the case, the extent of the record, the potential significance or novelty of the issues raised, and whether the Members can reach a consensus.

4. Can new information be sent to the Board on my case?

Yes. However, the Board cannot consider any information that was not admitted as evidence at the hearing level. But, if the Board considers the new information relevant, it may be presented to, and considered by the ALJ, provided that the Board decides to remand the case to the Hearings Division.

5. When will I receive the compensation due that was awarded by the ALJ's order (compensation stayed)?

A Board order becomes final 30 days after it is issued. If the compensation due is temporary disability ultimately found payable under the Board order for a period *before* the Board order, payment should begin within 14 days from the date the Board order becomes final. (Any ongoing temporary disability due *after* the Board order must begin to be paid within 14 days from the date of the Board order.) If the compensation due is permanent disability ultimately found payable under the Board order, payment should begin within 30 days from the date the Board order becomes final.



BRIEFING

BRIEFING SCHEDULE PRACTICE TIPS

Common Questions:

1. When is my brief due?

The appellant's brief is due 21 days from the date the Briefing Notice is distributed to the parties or their counsels. Respondent's/cross-appellant brief is due 21 days from the filing of the appellant's brief. The appellant's reply/cross-respondent brief is due 14 days from the filing of the respondent's brief, and the cross-reply is due 14 days from the filing of the appellant's cross-respondent's brief.

2. How do I file a brief?

The brief may be mailed to the Board at 2601 25th St. SE, Suite 150, Salem, OR 97302, or faxed to the Board Review Division at (503)373-1684. (Although the Board's rules allow an extension to be filed via the portal, that portion of the redesigning program is not yet complete.) Parties must send a copy of their brief to the other parties' attorneys, or if unrepresented, the other parties.

3. Do I have to send the brief certified mail?

The Board does not require parties to mail their briefs certified. The Board often receives briefs accompanied by a certificate of service by mail, certifying that the party mailed the brief to the Board on the date specified in the certificate.

4. My brief is due on a holiday or weekend. Is it really due that day?

If the due date falls on a Saturday, Sunday or a **state**-observed holiday, the brief will be due the next working day. (Columbus Day is not a state-observed holiday. Therefore, although no postal service is provided on Columbus Day, the Board's permanently-staffed offices are open.)

6. How do I file an extension request for my brief?

A request for extension must be filed with the Board in writing on or before the due date of the brief. "Filing" includes physical delivery at a permanently staffed office (Portland, Salem, Eugene, Medford), by mail, fax, or e-mail to request.wcb@oregon.gov. A copy of the request must be provided to the opposing party's attorney, or if unrepresented, to the party. (Although the Board's rules allow an extension to be filed via the portal, that portion of the redesigning program is not yet complete.) The extension request should include the following information:

- Claimant's name.
- WCB case number.
- The type of brief the extension is for; *i.e.*, appellant's, respondent's, reply, cross-reply.
- The original due date of the brief.
- The length of the requested extension (7, 14, 21 days?)
- The extraordinary circumstances that warrant the extension request.
- The position of the opposing party.

7. When will I receive notice of the Board's decision regarding my brief extension request?

Once the request is received by the Board Review Division, the decision will usually issue the following business day. Decisions are not announced by telephone, but the Board Review staff can confirm that the request has been received and whether the request contained all required information.

(Although the Board's rules allow an extension to be filed via the portal, that portion of the redesigning project is not yet complete. Once the portal "redesign" project is completed, portal users will be able to check their case to determine whether their extension request has been granted.)

8. I didn't receive the entire transcript/other party's brief; will the briefing schedule be extended/suspended?

The Board will suspend/extend the briefing schedule if the party meets the extraordinary circumstances detailed in number 6 in the extension/"waiver of rules" request. In submitting written notice to the Board, the requesting party should include the position of the other parties.

9. Can I fax my extension request?

Yes. The request can be faxed to the attention of the Board Review Division at (503)373-1684. It must be received by the Board on or before the original due date of the brief. The request may also be submitted through WCB's portal (once the portal has been developed to process such requests).



CLAIM DISPOSITION AGREEMENT (CDA) PROCEDURES

CLAIM DISPOSITION AGREEMENTS: PROCESSING TIPS

Some proposed CDAs neglect to fully comply with WCB rules. These proposals result in an addendum letter, requiring supplementation before receiving approval. To avoid future delays in the CDA approval process, parties and practitioners are reminded to double-check their agreement before submitting it for Board approval. As a means to reduce or eliminate these processing problems, the CDA Unit has listed the following common situations that result in addendum letters.

Confidentiality Clause. Some Claim Disposition Agreements (CDAs) contain a provision stating that the terms of the disposition will be kept confidential. An approved CDA constitutes a Board order and, as such, is a public document. Therefore, if the confidentiality provision of a proposed CDA purports to extend beyond the parties (to include the Board), the CDA is not approvable.

In addition, some proposed CDAs containing a “confidentiality” clause will occasionally include a “civil remedy” provision that purports to authorize a carrier to bring a civil action for damages for any breach of the “confidentiality” clause. The Board’s authority to approve CDAs does not extend to matters outside of chapter 656. *Karen A. Vearrier*, 42 Van Natta 2071 (1990). Consequently, if a “confidentiality” clause includes a “civil remedy” provision, the CDA will not be approved.

No vocational/work history. Always provide claimant’s extent of vocational training and a list of occupations that he/she has performed. OAR 438-009-0022(4)(e) and (f). (If claimant is deceased, provide the extent of vocational training and the work history for each of claimant’s beneficiaries. *Id.* If all surviving beneficiaries are minors, guardianship documents should be included.)

No highest education. CDA must include the highest level of education reached by claimant (or if deceased, his/her beneficiaries). *See* OAR 438-009-0022(4)(e).

Proceeds inconsistent. The amounts listed on the summary page and in the body of the CDA should be consistent. If a handwritten change has been made to amounts, all references to the amounts should be changed and all provisions in the CDA consistent. All parties or their representatives should initial/date the changes.

Assignment of Responsibility for Installment Payments of Structured Settlements. A carrier may assign its obligations to pay future installments of CDA payments, provided that the carrier remains ultimately responsible in the event that the assignee is unable to fulfill its obligation. *See Thomas H. Kistler*, 55 Van Natta 3310 (2003); *William I. Tarr*, 54 Van Natta 2071 (2002). Last updated 6/11/2015.

Medical Service-Related” Reservation. Parties/practitioners are encouraged to revise any proposed CDA provision that expressly addresses the release of future “aggravation rights,” “new/omitted medical condition claims,” “own motion relief” rights, and penalties/attorney fees (whether in the “summary page” or in the text of the CDA) to clarify that such a release is “partial” because the claimant remains entitled to any “medical service-related” benefits concerning such rights. *See Merritt Hopson, 67 Van Natta 1426 (2015).*

Payment of CDA Proceeds to Someone Other Than Claimant. For CDAs involving a child support lien, 25 percent of the total consideration (prior to the allowance for an attorney fee) is subject to the child support lien. *See ORS 656.234(2)(b); ORS 656.234(3)(c).* In other words, the total consideration is subject to the child support lien, rather than the total consideration after the attorney fee is deducted. *E.g., James F. King, Jr., 53 Van Natta 1096 (2001) (based on the total consideration of \$4,000, one fourth of the agreement proceeds, i.e., \$1,000, was subject to child support obligations); Jerry Ferguson, 50 Van Natta 240 (1998) (based on the total consideration of \$1,200, one fourth of the agreement proceeds, i.e., \$300, was subject to child support obligations).*

Missing signature lines. The CDA should contain signature lines for two Board Members who signed the agreement or the Administrative Law Judge who mediated the agreement (whichever is applicable).

Missing postcard. Provide a postcard for an unrepresented claimant. OAR 438-009-0028(2).

Missing pages. Some submitted CDAs have missing pages, often including the Order paragraph and Board Member signature lines. Before filing the CDA, double check that all pages have been included.

CDA/DCS submissions. Both agreements may be filed simultaneously. The DCS will be held until the CDA is approved; thereafter, notice of their approval will be announced together. If a claimant is unrepresented, the 30-day “cooling off” period under ORS 656.236 (1)(b) applies. Therefore, if the agreements are filed together, they will be held until expiration of the 30-day period.

No Copy Required - Signatures Need Not Be Original. A copy of the CDA is no longer required to be filed. OAR 438-009-0025(1). In addition, signatures of the parties and attorneys may be provided in writing, by FAX, or other electronic means. OAR 438-005-0046(4).

A CDA may include signatures that have been faxed or scanned between the parties/attorneys. However, that CDA must be filed with the Board via the portal, physical delivery to a permanently staffed office or to an ALJ-Mediator, or by means of U.S. Mail.

CDA Approval - On-Line Notification. Notification of approval is provided via the portal. In addition, WCB's website allows parties and practitioners to access information concerning approved Claim Disposition Agreements (CDAs). Specifically, WCB posts a list of approved CDAs, which are compiled on a daily basis. This notification confirms that the listed CDAs have been approved by two Board Members or an ALJ/Mediator. The list is updated daily, including the date of approval, claimant name, and CDA number. A link to the CDA web page can be accessed at:
<http://www.oregon.gov/wcb/board-orders/Pages/index.aspx>.

ALJ-MEDIATOR APPROVAL FOR CDAs

A CDA may be approved by either the Board Members or, if the CDA is a product of a mediation, the Administrative Law Judge (ALJ) who mediated the CDA.

To assist the Board in processing these agreements as expeditiously as possible, parties and practitioners are encouraged to consider the following matters:

1. If a CDA is filed with the Board's Salem office and there is no cover letter nor any indication in the CDA that the parties wish to have the ALJ who mediated their agreement approve it, the CDA will be forwarded to the Board Members for their review and approval.
2. If the parties wish to have the ALJ who mediated their CDA approve it, they can hand deliver the agreement to the ALJ, mail it to the ALJ's home office, mail it to the Board's Salem office in care of the ALJ-Mediator, or file it via the portal with a cover letter expressing their intentions. In this way, WCB staff can readily identify a CDA that is intended to be submitted to the ALJ-Mediator.
3. If the parties are also submitting a Disputed Claim Settlement (DCS) (which resolves a dispute pending at the Hearings Division), along with the CDA, and those agreements have been the product of a mediation, and the parties wish to have the ALJ-Mediator approve both agreements, the parties should deliver the agreements in the manner described in Section 2.
4. An exception to Section 3 arises when the DCS is resolving a dispute that is pending appeal before the court or the Board. Because the Board (rather than the ALJ) has sole authority to review and approve the DCS, the parties should consider filing both agreements with the Board. In this way, the Board can complete its review/approval of the CDA and then immediately proceed to the DCS. Alternatively, if the parties wish to have the CDA approved by the ALJ who mediated the agreement, they can submit the agreements separately; the DCS to the Board and the CDA to the ALJ-Mediator. Because this latter approach will likely delay the review/approval process for the agreements, the parties should consider submitting both agreements to the Board for the Members' review/approval.

Any questions regarding the processing of CDAs may be directed to Nancy Coffelt, the CDA Coordinator, at (503)934-0116. ALJ-Mediator processing questions may be directed to Monte Marshall, Assistant Presiding ALJ, at (503)378-3308.

FREQUENTLY ASKED QUESTIONS

1. When will my CDA be approved?

If claimant is represented by an attorney and is waiving 30 days: It generally takes 7 to 10 days from the date the CDA is received by WCB for the CDA to receive Board approval. Circumstances which can extend the time for approval are Board requests for further information, clarification, or an addendum letter.

If claimant is unrepresented: A CDA involving an unrepresented claimant cannot be approved until the 31st day from the date the CDA is received by WCB. *See* ORS 656.236(1)(a)(C) and (1)(b).

2. What are circumstances that may delay Board approval of the CDA?

The CDA may include an omission or ambiguity, which requires the issuance of an addendum letter to the parties to amend, supplement, or clarify the CDA.

3. Why does the CDA need to be reviewed? I read it and agree with it the way it is.

The Board or the ALJ-Mediator are required by law to confirm that the CDA complies with the law and that there are no errors, inconsistencies, or ambiguities.

4. Why can't an unrepresented claimant waive the 30 days?

The Board or the ALJ-Mediator are required by law to give unrepresented claimants 30 days from the date of receipt of the CDA an opportunity to withdraw the CDA if they change their minds.

5. Can I hand deliver a CDA or addendum?

Yes, you can file a CDA through the portal or physically deliver a CDA or addendum at any of WCB's staffed offices. The addresses for WCB's staffed offices are:

Salem: 2601 25th St. SE, Ste. 150

Portland: 16760 SW Upper Boones Ferry Rd., Ste. 220

Eugene: 1140 Willagillespie Rd., Ste. 38

Medford: 115 W Stewart Ave., Ste. 102

6. Can you expedite my CDA?

The Board or the ALJ-Mediator will be notified of your request. However, when claimant is unrepresented, approval cannot be granted until the 31st day after receipt of the CDA.

7. When will I get my check?

The carrier has 14 days after the CDA is approved to issue a check, unless otherwise stated in the agreement. Concerns regarding late payment should be directed to the Benefit Consultation Unit at the Workers' Compensation Division at 1-800-452-0288 or (503)947-7840 in Salem.

CLAIM DISPOSITION AGREEMENT CHECKLIST

NAME: _____ C

OK/CK*** UNREP NO WVR _____ WAIVER Summary _____
NEED UNREP PC _____ Body _____

- _____ 1. **SUMMARY PAGE/CAPTION/IDENTIFY BENEFITS TO BE RELEASED**
- _____ 2. PREFERRED WORKER
- _____ 3. ATTORNEY FEES/PENALTIES
- _____ 4. ATTORNEY FEE/AND WITHIN AMOUNT ALLOWED
- _____ 6. CLAIMANT CONSIDERATION/AMOUNT CORRECT
- _____ 7. **CDA PROVIDES TOTAL CONSIDERATION** _____
- _____ 8. IDENTIFIES ACCEPTED CONDITIONS SUBJECT OF CDA _____
- _____ 9. DATE OF FIRST CLAIM CLOSURE IF APPLICABLE _____
- _____ 10. PERMANENT DISABILITY AWARD IF APPLICABLE _____
- _____ 11. PROVIDES WHETHER CLAIMANT HAS RETURNED TO WORK FORCE _____
- _____ 12. PROVIDES WORKER'S AGE _____
- _____ 13. PROVIDES HIGHEST EDUCATION LEVEL _____
- _____ 14. PROVIDES VOCATIONAL TRAINING _____
- _____ 15. PROVIDES WORK HISTORY _____
- _____ 16. PROVIDES SPECIFIC IDENTIFICATION OF BENEFITS, RIGHTS & OBLIGATIONS TO BE RELEASED (EXCLUDING MEDICAL BENEFITS)
- _____ 17. RECITES THAT CLAIMANT PROVIDED INFORMATIONAL FLYER
-AND/OR-
ATTACHES FLYER AS INCORPORATED BY REFERENCE
- _____ 18. PROVIDES NOTICE IN PROMINENT OR BOLD FACE TYPE
-AND/OR-
ATTACHES NOTICE TO CLAIMANT AS INCORP BY REF
- _____ 19. PROVIDES SIGNATURES OF ALL REQUIRED PARTIES
- _____ 20. PROVIDES ORDER PARAGRAPH
- _____ 21. PRIOR APPROVAL OF DIRECTOR - IF REQUIRED FOR REIMBURS

RECOMMENDATIONS

DISAPPROVAL (DRAFT ORDER ATTACHED)

_____ DISAPPROVAL REQUESTED BY CLAIMANT/CARRIER
_____ CDA IS RESULT OF "INTENTIONAL MISREPRESENTATION"
_____ CDA IS "UNREASONABLE AS MATTER OF LAW"

COMMENTS: _____

APPROVAL : _____

COMMENTS: _____

MEMBER DECISION

1ST MEMBER (STAMP APPROVED): _____ DATE: _____

COMMENTS: _____

2ND MEMBER (STAMP APPROVED): _____ DATE: _____

COMMENTS: _____

BEFORE THE WORKERS' COMPENSATION BOARD OF

THE STATE OF OREGON

In the Matter of the Compensation) CDA No. _____
) WCB Case No. _____
) Claim No. _____
 of) DOI _____
) WCD File No. _____
) Insurer/Employer _____
)
 _____, Claimant) CLAIM DISPOSITION AGREEMENT

TYPE OF RELEASE

ISSUE/BENEFIT RELEASED

Full	Partial	
<input type="checkbox"/>	<input type="checkbox"/>	Temporary Disability
<input type="checkbox"/>	<input type="checkbox"/>	Permanent Disability
<input type="checkbox"/>	<input type="checkbox"/>	Vocational Assistance
<input type="checkbox"/>	<input type="checkbox"/>	Survivor's Benefits
<input type="checkbox"/>	<input type="checkbox"/>	Other: All rights under ORS Chapter 656 other than those related to medical services under ORS 656.245 and eligibility for preferred worker status.

AMOUNT OF DISPOSITION

\$ _____ Total Due Attorney
(Subject to WCB approval)

\$ _____ Total Due Claimant

METHOD OF PAYMENT (check one)

WAIVER OF "30-DAY" PERIOD

Lump Sum
 Structured Settlement
 Both of the Above

YES
 NO

1. Claimant's name and address: _____
2. Employer's name and address: _____
3. Carrier's name and address: _____
4. Claimant's attorney's name and address _____
5. Employer's/Insurer's attorney's name and address: _____
6. The accepted conditions subject to this claim disposition agreement are: _____
7. This claim was first closed on: _____
8. The total amount (percent) of permanent disability benefits awarded on the claim is:

9. The worker has / has not ever been able to return to the work force following the industrial injury or occupational disease.
10. The worker's age is _____ and his/her highest educational level is _____.
The extent of vocational training (or, if the worker is deceased, the age, highest education level, and the extent of vocational training of the worker's beneficiary(ies)) is/are

11. The following is a list of occupations that the worker has performed (or, if the worker is deceased, a list of occupations that each of the deceased worker's beneficiaries has performed): _____
12. Pursuant to ORS 656.236, in consideration of the payment of \$ _____ by the insurer/employer, claimant releases his/her right to the following workers' compensation benefits: _____ and all other rights under ORS Chapter 656 other than those related to medical services under ORS 656.245.
The insurer's/employer's obligation to provide these benefits is also released.
13. Out of the above consideration, claimant's attorney shall receive an attorney fee in the amount of \$ _____ (which the parties confirm is consistent with OAR 438-015-0052).
 - a. If the attorney fee exceeds the Board's rule (OAR 438-015-0052), the extraordinary circumstances that justify this fee are _____ .
 - b. If the agreement is to be paid in installments beyond one year, the cost of the annuity or the present value of the agreement is \$ _____ .

14. Claimant retains his/her right to medical service-related benefits for the compensable injury (including medical services allowed under ORS 656.245, ORS 656.273 and ORS 656.278, as well as penalties/attorney fees related to such medical service claims) and his/her eligibility for preferred worker status.
15. Claimant was given a written informational enclosure, separate from the agreement, in the form prescribed by the Board pursuant to OAR 438-009-0022.
16. [The following notice must either be included in the claim disposition agreement or incorporated by reference into the agreement].

"NOTICE TO CLAIMANT: UNLESS YOU ARE REPRESENTED BY AN ATTORNEY AND YOUR CLAIM DISPOSITION AGREEMENT INCLUDES A PROVISION WHICH WAIVES THE 30-DAY "COOLING OFF" PERIOD, YOU WILL RECEIVE A NOTICE FROM THE WORKERS' COMPENSATION BOARD OR THE ADMINISTRATIVE LAW JUDGE WHO MEDIATED THE AGREEMENT TELLING YOU THE DATE THIS AGREEMENT WAS RECEIVED BY THEM FOR APPROVAL. YOU HAVE 30 DAYS FROM THE DATE THE BOARD OR THE ADMINISTRATIVE LAW JUDGE WHO MEDIATED THE AGREEMENT RECEIVES THE AGREEMENT TO REJECT THE AGREEMENT, BY TELLING THE BOARD OR THE ADMINISTRATIVE LAW JUDGE WHO MEDIATED THE AGREEMENT IN WRITING. DURING THE 30 DAYS ALL OTHER PROCEEDINGS AND PAYMENT OBLIGATIONS OF THE INSURER/SELF-INSURED EMPLOYER, EXCEPT FOR MEDICAL SERVICES, ARE STAYED ON YOUR CLAIM. IF YOU DO NOT HAVE AN ATTORNEY, YOU MAY DISCUSS THIS AGREEMENT WITH THE BOARD IN PERSON WITHOUT FEE OR CHARGE. TO CONTACT THE BOARD, WRITE OR CALL: WORKERS' COMPENSATION BOARD, 2601 25TH STREET SE, SUITE 150, SALEM, OREGON 97302-1280, TELEPHONE: (503) 378-3308, TOLL-FREE AT 1-877-311-8061, 8:00 TO 5:00, MONDAY THROUGH FRIDAY.

"YOU MAY ALSO DISCUSS THIS AGREEMENT WITH THE OMBUDSMAN FOR INJURED WORKERS, WITHOUT FEE OR CHARGE. TO CONTACT THE OMBUDSMAN, WRITE OR CALL: OMBUDSMAN FOR INJURED WORKERS, LABOR & INDUSTRIES BUILDING, 350 WINTER STREET NE, SALEM, OR 97310, TELEPHONE: TOLL-FREE AT 1-800-927-1271, 8:00 TO 5:00, MONDAY THROUGH FRIDAY.

"YOU MAY ALSO CALL THE WORKERS' COMPENSATION DIVISION'S INJURED WORKER HOTLINE, TOLL-FREE, AT 1-800-452-0288."

17. Payment of the disposition shall be made no later than the 14th day after notice of the Board's approval has been mailed or distributed to the parties or their representatives under OAR 438-009-0030(5) and (6) by means of an order, posting on WCB's website, electronic distribution through WCB's website portal, or postcard. *See* OAR 438-009-0028; OAR 438-009-0030(7).
 18. On Board approval of this agreement, the following requests for hearing/review pending before the Hearings Division, Board, or Court shall be dismissed: WCB Case No(s).
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19. Claimant acknowledges that he/she has reviewed the description of benefits, as described in this agreement and the informational enclosure prescribed in OAR 438-009-0022, and has had an opportunity to ask questions of his/her attorney or the insurer/employer to further understand the consequences of signing this agreement.
20. [This item applies if the parties are waiving "cooling off" period.] Claimant is represented by an attorney and all parties agree to waive the "30 day" waiting period under ORS 656.236(1)(a)(C) for Board approval of the agreement.

IT IS SO STIPULATED AND AGREED.

_____	_____
Claimant	Date
_____	_____
Claimant's Attorney	Date
_____	_____
Insurer/Employer	Date
_____	_____
Insurer's/Employer's Attorney	Date

THIS AGREEMENT IS IN ACCORDANCE WITH THE TERMS AND CONDITIONS PRESCRIBED BY THE BOARD. SEE ORS 656.236(1). ACCORDINGLY, THIS CLAIM DISPOSITION AGREEMENT IS APPROVED. AN ATTORNEY FEE PAYABLE TO CLAIMANT'S ATTORNEY ACCORDING TO THE TERMS OF THIS AGREEMENT IS ALSO APPROVED.

IT IS SO ORDERED.

DATED THIS _____ DAY OF _____, 20____.

Board Member or Administrative Law Judge Who Mediated the Agreement

Board Member

NOTICE TO ALL PARTIES: THIS ORDER IS FINAL AND IS NOT SUBJECT TO REVIEW. ORS 656.236(2).

CLAIM DISPOSITION AGREEMENT INFORMATIONAL ENCLOSURE

Under ORS 656.236, you may settle a workers' compensation claim except for medical benefits. Such a settlement is usually called a "claim disposition agreement" or "CDA." If you are thinking about settling your claim in this way, there are things you should know.

WHAT DO I GET? WHAT DO I GIVE UP?

In return for an agreed upon amount of money, you may give up or "release" your right to such things as:

- Present and future time loss benefits, which is money paid to compensate you for temporary lost wages related to your industrial injury or occupational disease.
- Present and future permanent disability awards, which is money paid for permanent impairment and/or lost earning capacity related to your industrial injury or occupational disease.
- Monthly payments for permanent total disability, which is money paid for permanent and total incapacity, as a result of your industrial injury or occupational disease, from regularly performing work at a gainful and suitable occupation.
- Vocational assistance benefits, which is a vocational evaluation and possible retraining to assist you in returning to the work force.
- Survivor benefits, which is money paid to a deceased worker's family.
- Penalties and attorney fees, which is money paid as a result of an employer's/insurer's unreasonable claim processing practices or for prevailing against an employer's/insurer's claim denial.

There are only two things you are not allowed to release in a CDA. You cannot release your rights to medical service-related benefits and you cannot waive your eligibility for preferred worker status. ORS 656.236(1)(a); ORS 656.622(4)(b).

If your permanent disability award has not been fully paid, you could lose any unpaid award by signing a CDA, unless the CDA provides for full payment of your award or you ask the insurer for a "lump sum" payment of the award prior to submission of the CDA to the Workers' Compensation Board.

If you are disabled under social security, contact the Social Security Administration to learn how a CDA affects your disability benefits. If the amount of the CDA is offset from your social security payments, you could receive no income from social security until the offset is complete.

If you are paying child support, moneys payable from the CDA are subject to an order to enforce child support obligations.

REQUIREMENTS AND RESTRICTIONS

There are requirements and restrictions that apply if you decide to settle your claim.

The CDA must identify released benefits.

The CDA must tell you exactly what benefits are being released. This helps you compare the benefits you could normally expect to receive for your claim with the dollar amount being offered you.

You must be informed about the meaning of a CDA.

This enclosure has been prepared by the Workers' Compensation Board to explain the basic meaning of claim disposition. However, you may want more specific information.

If you do not have an attorney, you may consult the Ombudsman for Injured Workers, whose job it is to help injured workers. You also have the right to personally meet and discuss the proposed CDA with the Workers' Compensation Board. There are no fees or charges for these services.

You have the right to an attorney.

If you wish, you may retain an attorney. The attorney may charge a fee if the CDA is approved by the Workers' Compensation Board or the Administrative Law Judge (ALJ) who mediated the CDA. The fee will be subtracted from the CDA. You also may have to pay the attorney for costs incurred while working on the CDA, even if no agreement is reached.

continued next page

MEDICAL BENEFITS/PREFERRED WORKER STATUS

Because you cannot release your right to medical benefits or waive your eligibility for Preferred Worker status, the Workers' Compensation Division can continue to help you and your doctor resolve problems.

If you have any questions about your rights to medical benefits, call the Benefit Consultation Unit at the numbers shown at the end of this notice.

WHAT IF I CHANGE MY MIND?

After you sign the CDA, it will be sent to the Workers' Compensation Board or the ALJ who mediated the CDA. Once the Board or the ALJ who mediated the CDA receives it, the CDA cannot be approved for 30 days unless you are represented by an attorney and the CDA includes a provision waiving the 30-day "cooling off" period. Unless the CDA states otherwise, no benefits will be paid to you during this 30-day "cooling off" period. If the first day after the expiration of the 30-day "cooling off" period is on a weekend or state holiday, the CDA cannot be approved until the next business day.

If you change your mind before the 30 days are up or before the CDA is approved, you must write the Board or the ALJ who mediated the CDA and ask that the CDA be disapproved. If you do not request disapproval, the CDA will be approved unless the Board or the ALJ who mediated the CDA finds it unreasonable as a matter of law or the result of misrepresentation. Once approved, the CDA is final and cannot be appealed.

If the CDA does not comply with all applicable rules, the Board or the ALJ who mediated the CDA may ask that the CDA be amended. This process can sometimes delay approval of the CDA. Once the written CDA amendment is filed, review will continue. If the CDA is approved, you have 10 days to ask for reconsideration. If the CDA is disapproved, the insurer must resume paying your benefits if they are due. If the CDA is disapproved, the parties have 30 days to appeal the decision to the Court of Appeals.

WAIVER OF 30-DAY "COOLING OFF" PERIOD

If the CDA waives the 30-day "cooling off" period and complies with all applicable rules, it will receive approval within approximately 14 days after the CDA is filed.

PAYMENT OF CDA

Payment of the CDA must be made no later than the 14th day after approval unless otherwise stated in the CDA. If payment is not made, you should contact the insurer, or your attorney. If you need further assistance you may contact the Benefit Consultation Unit, or the Ombudsman for Injured Workers. The Board or the ALJ who mediated the CDA is unable to assist you with nonpayment of the CDA.

QUESTIONS -- CALL THESE NUMBERS:

Benefit Consultation Unit Injured Worker Hotline:

Toll free...1-800-452-0288

Ombudsman for Injured Workers:

Toll free...1-800-927-1271

Workers' Compensation Board

Claim Disposition Agreement Unit:

Toll free...1-877-311-8061

Salem(503)934-0116

**Notice to Spanish Speaking Claimants*

Aviso Para El Reclamante: Este es un documento importante que puede afectar su caso. Usted es urgido fuertemente a conseguir ayuda inmediata con respecto al significado de este documento y sus derechos y responsabilidades en relación con ello. Tal ayuda puede ser obtenida por comunicarse con el Representante de la Compensación para Trabajadores en Español línea gratis 1-800-927-1271.



**DISPUTED CLAIM SETTLEMENT (DCS)
PROCEDURES**

**DISPUTED CLAIM SETTLEMENT (DCS) AND STIPULATION
PROCESSING TIPS
FOR CASES ON BOARD REVIEW**

Periodically, the Board receives proposed settlements that do not comply with applicable rules or raise questions requiring further clarification. Because these situations can result in amended or supplemented agreements, which inevitably lead to delays in the review/approval process, the following tips have been compiled to assist practitioners in submitting proposed settlements.

1. Immediately notify the Board (by calling (503)934-0103, or using the Board's online settlement notification process) if the parties have agreed to resolve a dispute that is pending Board review. The notifying party must confirm the settlement in writing.
2. A proposed settlement should be accompanied by a cover letter that clearly indicates the parties' intentions. Also, if the settlement is resolving disputes at multiple levels, the letter should make that point.
3. All WCB case numbers should be included in the caption of the settlement. The proposed agreement should be submitted to the litigation level where the dispute is currently pending (Hearings Division or Board). If there are disputes at multiple levels, agreements should be directed to the Board's Salem office.
4. Settlements should recite the procedural posture of the case, including a description of any relevant litigation decisions. The Board has authority to approve a DCS that resolves issues before the court. ORS 656.298(9)(a); *Rebecca E. Seelye*, 60 Van Natta 332 (2008).
5. A DCS must contain the information required by OAR 438-009-0010(1).
6. Settlements should identify all disputes being resolved. For instance, if a DCS includes a current condition denial, but is also resolving a dispute regarding a prior denial litigated before an ALJ and on appeal before the Board, the DCS should refer to both denials.
7. A DCS concerns the resolution of bona fide disputes over compensability. ORS 656.289(4); OAR 438-009-0010(2). Occasionally, a DCS is combined with a stipulation that resolves other issues, such as temporary or permanent disability. Such agreements are permissible, provided that the parties' intentions are apparent and the applicable administrative rules are satisfied.
8. When reimbursement of medical bills in a DCS exceeds the statutory reimbursement formula in ORS 656.313(4), the agreement must contain claimant's express consent to such a reimbursement. *See Charles E. Munger*, 46 Van Natta 462 (1994).

9. If the attorney fee provided in a DCS exceeds the “standard” amount, the agreement must contain an acknowledgment and description of the “extraordinary circumstances” warranting such an attorney fee. Agreements describing the following “extraordinary circumstances” have previously received Board approval: complex issues (procedurally and/or substantively); protracted litigation; a voluminous record; extraordinary hours performed by claimant’s counsel; and a claimant’s counsel’s prior success at the hearing and/or Board review level, which had previously resulted in an attorney fee award.
10. A DCS of a claim involving a previously accepted condition must contain a provision that addresses the claimant’s entitlement to future benefits arising under ORS 656.245, ORS 656.273, ORS 656.278 and ORS 656.340. OAR 438-009-0010(4)(b).
11. Some DCSs contain a statement that claimant agrees to waive all rights to pursue a civil action against the employer. The Board’s approval of a DCS does not extend to such a provision. *See Claude A. Benson*, 55 Van Natta 3935 (2003).
12. Some DCSs contain a provision that provides for reimbursement of an insurance carrier’s lien. Such a provision is considered an assignment of claimant’s share of the DCS proceeds and is permissible. *See Michele Groth*, 61 Van Natta 2788 (2009).
13. If a carrier assigns an ongoing obligation to make settlement payments to another entity, the carrier must retain potential responsibility for payments under the agreement should that entity not fulfill its obligations. *See Jeff Shaddon*, 58 Van Natta 1354 (2006).
14. In cases involving stipulations concerning temporary and permanent disability or penalties and attorney fees, parties should ensure that the applicable attorney fee, temporary and permanent disability rules and statutes are satisfied. *See e.g.*, ORS 656.262(11)(a); OAR 438-015-0050.
15. When considering settlements involving structured installment payments, include a provision quantifying the present value or value of the annuity for attorney fee purposes. OAR 438-015-0052.
16. Parties may resolve issues such as permanent disability, temporary disability, penalties and attorney fees that are pending before the Hearings Division or on Board review by means of a CDA. In such cases, the CDA should include a provision that, on approval of the CDA, the request for hearing or Board review will be dismissed.
17. In cases involving accepted conditions, parties may choose to resolve all outstanding issues by means of a “global settlement,” in which the parties submit both a DCS and a CDA. Such agreements are permissible, provided that all settlement documents comply with applicable administrative rules, statutes and legal precedent.

18. When one or more of the multiple agreements require Board Member approval, parties/practitioners are encouraged to submit all proposed agreements to the Board's Salem office (to ensure uniform, centralized, and expedited processing).

DCS CHECKLIST

- _____ Make sure any interlineations in an agreement been initialed by the parties and their attorneys and claimant.
- _____ The attorney fee in a DCS should conform to OAR 438-015-0050. (Absent extraordinary circumstances, 25 percent of the first \$50,000, 10 percent of the remaining proceeds.)
- _____ The settlement must contain the date on which the terms of settlement were reached. (*See* OAR 438-009-0010(2)(h).)
- _____ Does the document contain a list of medical service providers' bills in the carrier's possession on the settlement date, including the specific amount each provider will receive and the parties' acknowledgment that the reimbursement is in accordance with ORS 656.313(4)? (OAR 438-009-0010(g).)
- _____ If reimbursement to medical providers is in excess of 40 percent of the present value of the disputed claim settlement and/or if the providers are being reimbursed at more than 50 percent of the adjusted amounts, has claimant knowingly consented to the higher-than-required payments? (*See Charles E. Munger, 46 Van Natta 462 (1994).*)
- _____ If the denial was of aggravation, or of current condition, or of a condition on the grounds that it is not related to an accepted injury, does the settlement document recite that claimant retains those rights that may later arise under ORS 656.245, ORS 656.273, ORS 656.278, and ORS 656.340? (*See* OAR 438-009-0010(4)(b).)
- _____ If claimant is unrepresented, the DCS should recite that claimant has been orally advised of his right to an attorney at no cost for attorney fees, informed of the existence of the office of the Ombudsman, and advised of the "medical bills" reimbursement schedule and his/her potential responsibility for any remaining outstanding balance. (*See* OAR 438-009-0010(5).)
- _____ Does the document recite that claimant has been orally advised of the information listed in detail at OAR 438-009-0010(6)?
- _____ Does the document contain the language concerning claim disposition agreements, which language is required by OAR 438-009-0010(8)?



PUBLIC RECORD REQUESTS

REQUEST FOR PUBLIC RECORDS

Frequently Asked Questions

1. How do I make a public records request?

All requests must be in writing and directed to the attention of the Board's Executive Assistant, Katy Gunville, at 2601 25th St. SE, Salem, OR 97302. The fax number is (503)373-1684.

2. Are materials in WCB files considered a public record?

No. Exemptions to the Public Records Law are workers' compensation claim records of the Department of Business and Consumer Services. ORS 192.502(20). Any file material from a WCB litigation record constitutes claim records of the Department.

3. What information can be released?

Orders issued by an ALJ, Board Orders, Claim Disposition Agreements (CDA), Stipulations, and Disputed Claim Settlements (DCS) are considered public records.

4. Who do I contact to request a copy of an order?

The Board's orders are available on its website at www.wcb.oregon.gov. If you are a party to a case, you have access to obtain a copy of a final order through the portal. Otherwise, you may contact Katy Gunville at (503)934-0123.

5. How do I request other information from a WCB file?

If you **are** a party or a party representative you will need to put your request in writing as follows: 1) For cases currently pending at the Hearings Division level, the request should be made to the Hearings Division (or the specific ALJ assigned to the case), or 2) For cases currently on Board Review, the request should be made to the Board's Executive Assistant.

If you are **not** a party to the case, you must put your request in writing and direct it to the attention of the Board's Executive Assistant.

6. What rules apply to hearing transcripts?

Because hearings are open to the public, the Attorney General's office has determined that a CD of the hearing is considered a public record. However, a public body is not required to make a *transcript*, only to make a copy of the CD from the hearing

available to the requestor. Therefore, anyone requesting such information is entitled to either purchase a copy of the CD or incur the cost of transcription.

7. How do I request a copy of a hearing transcript?

If you **are** a party to the case, you may contact our Transcription Coordinator at (503)934-0142 to request a CD of the hearing.

If you are **not** a party to the case, you will need to put your request in writing to the attention of the Board's Executive Assistant. Include in your request detailed information such as claimant's name, WCB case number, and the date of hearing.



OWN MOTION

BOARD'S WEBSITE – <http://www.wcb.oregon.gov>
“OWN MOTION INFORMATION” LINK

The “Own Motion Information” link in the ribbon on the left side of the above website address provides Own Motion forms, bulletins, and claim processing aids, including:

- Frequently Asked Questions
- Own Motion Check List
- Own Motion Flow Chart
- WCB Own Motion Forms:
 - WCB Bulletin 1-2005 (1/1/2006)
 - Carrier’s Own Motion Recommendation (Form 440-2806)
 - “Worsened Conditions Claims” – “Claim Processing” Scenarios
- WCD Own Motion Forms:
 - WCD Bulletin 195 (Revised) (1/1/2006)
 - Reopened Claims Program Reimbursement Request (Form 440-1966)
 - Notice of Closure: Own Motion Claim (Form 440-2066)
 - Notice of Voluntary Reopening Own Motion Claim (Form 440-3501)
- Own Motion Digest

OWN MOTION OVERVIEW

A. A claim in Own Motion status is:

For every compensable injury, a worker is given a 5-year period in which to file a claim for aggravation or worsening of that injury (“aggravation rights”). Aggravation rights expire 5 years from the date of the first closure of a disabling claim or 5 years from the date of injury of a nondisabling claim. ORS 656.273(4). After a worker’s aggravation rights expire, the worker’s claim is in the Board’s Own Motion jurisdiction under ORS 656.278. The types of benefits available for Own Motion claims and the requirements to receive those benefits differ from claims for which aggravation rights have not expired.

B. “Own Motion Claim” is defined as:

1. A new medical condition or an omitted medical condition that is related to an initially accepted claim that has been “determined to be compensable” and that was initiated after the rights under ORS 656.273 expired (*i.e.*, a “post-aggravation rights” new medical condition or omitted medical condition claim). OAR 438-012-0001(2)(b).
2. A written request by or on behalf of a claimant for temporary disability compensation or claim reopening regarding a “worsened condition” that has been “determined to be compensable” and that was initiated after the rights under ORS 656.273 expired (*i.e.*, a “post-aggravation rights” “worsened condition” claim). OAR 438-012-0001(2)(a).

C. For a “post-aggravation rights” new/omitted medical condition claim, “determined to be compensable” is defined as:

1. The carrier has issued a notice of acceptance under ORS 656.262(7)(a); or
2. The carrier’s denial under ORS 656.262(7) or ORS 656.308(2) or *de facto* denial has been set aside by an order from an Administrative Law Judge, the Board, or the court. OAR 438-012-0001(4)(a), (b).

Compensability issues regarding “post-aggravation rights” new/omitted medical condition claims are “regular” compensability issues that must be processed under ORS 656.262, rather than ORS 656.278(1)(b).

D. The carrier is required to process the Own Motion claim after the “post-aggravation rights” new/omitted medical conditions “have been determined compensable.”

1. Under the Board’s rules, such Own Motion claim processing must occur within 30 days after the condition “has been determined compensable.” OAR 438-012-0030(1). This 30-day processing period begins with the *initial* determination of compensability, whether that initial determination is made by the carrier, an Administrative Law Judge, the Board, or the court. A failure to comply with this requirement can result in the assessment of penalties and attorney fees. *See Troy J. Pachano*, 62 Van Natta 509 (2010).
2. Subject to the situation described below in item (c), because there are no additional requirements for reopening a “post-aggravation rights” new/omitted medical condition claim, if such a claim is determined compensable and the carrier does not appeal that determination, Own Motion processing would consist of the carrier either:
 - (a) voluntarily reopening the claim for Own Motion relief; or
 - (b) submit a “Carrier’s Own Motion Recommendation” for reopening the claim for Own Motion relief.¹ OAR 438-012-0030(1)(a), (b).
 - (c) Notwithstanding item (b), if the carrier appeals the initial litigation order finding the claim compensable, the carrier should within 30 days submit a “Carrier’s Own Motion Recommendation” against reopening the claim for Own Motion relief based on its appeal of that litigation order. If the “initial litigation order” was an ALJ’s order, consistent with its longstanding practice, the Board would consolidate review of the two issues, deciding the compensability issue in its “regular” jurisdiction by means of an Order on Review and the “claim reopening” issue in its Own Motion jurisdiction by means of an Own Motion Order.

¹ Entitlement to benefits on an open Own Motion claim is a claim processing matter that is separate from the issue of whether the claim qualifies for reopening. A claim may qualify for reopening but not qualify for payment of temporary or permanent disability benefits. ORS 656.278(1), (2); *Duane L. Leafdahl*, 54 Van Natta 1796, 1799 (2002).

If the “initial litigation order” was an appealed Board order, the carrier should as soon as possible but within 30 days, submit a recommendation against claim reopening. In that situation, the Board would likely issue a “claim reopening” order, relying on its appealed compensability order. Thereafter, the carrier could appeal the Board’s Own Motion “claim reopening” order and request the court to consolidate its review of the two appealed Board orders.

3. There are no requirements for “inability to work,” “requisite medical treatment,” or “work force” to reopen a “post-aggravation rights” new or omitted medical condition claim. *Donald L. Duquette*, 59 Van Natta 691 (2007); *Charles Klutsenbeker*, 55 Van Natta 2244 (2003); *Duane L. Leafdahl*, 54 Van Natta 1796 (2002).
4. If the “claim” is never “determined to be compensable,” the carrier’s responsibility for Own Motion processing does not materialize. *James J. Jordan*, 58 Van Natta 34 (2006); *Rosemary A. Barnes*, 59 Van Natta 928 (2007) (applies *Jordan*).

E. For a “worsened condition” claim, “determined to be compensable” is defined as:

1. The carrier does not dispute compensability of or responsibility for the current condition; *i.e.*, the carrier has not issued a denial under ORS 656.262(6) or ORS 656.308(2) and there is not a *de facto* denial of the current condition; or
2. The carrier’s denial under ORS 656.262(6) or ORS 656.308(2) or *de facto* denial of the current condition has been set aside by an order from an Administrative Law Judge, the Board, or the court. OAR 438-012-0001(3)(a), (b)

F. “Worsened Condition” Claims

1. Unlike “post-aggravation rights” new/omitted medical condition claims, “worsened condition” claims have other requirements for reopening in addition to the claim being determined compensable:
 - (a) The worsening must result in the partial or total inability of the worker to work;
 - (b) The worsening must require hospitalization, surgery (either inpatient or outpatient), or other curative treatment prescribed in lieu of hospitalization that is necessary to enable the worker to return to work;
 - (c) The worker must be in the work force at the time of disability as defined under the criteria in *Dawkins v. Pacific Motor Trucking*, 308 Or 254 (1989); and
 - (d) The requisite medical treatment must not be challenged by the carrier under ORS 656.245, ORS 656.260, and/or ORS 656.327.

ORS 656.278(1)(a); *Timothy A. Hall*, 61 Van Natta 2164 (2009)(work force requirement not satisfied); *Dale T. Dreyer*, 61 Van Natta 2076 (2009) (no worsening of compensable condition that required surgery, hospitalization, or any other requisite treatment under ORS 656.278(1)(a)); *Hallie E. Holland*, 60 Van Natta 3463 (2008) (work force requirement satisfied); *Randy A. Eggleston*, 59 Van Natta 2661 (2007)

(palliative care; medical treatment requirement under ORS 656.278(1)(a) not satisfied); *Victor J. Cervantes*, 58 Van Natta 755 (2006) (Director found proposed surgery not reasonable or necessary; medical treatment requirement under ORS 656.278(1)(a) not satisfied); *Andrew J. Duby*, 57 Van Natta 833 (2005) (no medical evidence that the claimant's compensable condition worsened resulting in partial or total inability to work); *Larry D. Little*, 54 Van Natta 2536 (2002) (explains medical treatment requirement under ORS 656.278(1)(a)); *James J. Kemp*, 54 Van Natta 491 (2002).

2. Including the determination of compensability in the definition of an "Own Motion claim" for a "worsened condition" in the Board's rules did not effect the additional requirements for reopening a "worsened condition" claim described above in item (F-1). In other words, the case law regarding these additional requirements remains applicable. Furthermore, jurisdiction regarding Own Motion "worsened condition" claims remains bifurcated. That is, compensability of "current conditions" or medical services related to a "post-aggravation rights" claim is within the Hearings Division's original jurisdiction. However, the determination of the remaining factors required to reopen a "worsened condition" claim under ORS 656.278(1)(a) is within the Own Motion Board's jurisdiction: (a) "inability to work" factor; (b) medical treatment factor; and (3) work force status at the date of disability.²

Therefore, the Own Motion Board retains the authority to refer a dispute regarding any of these additional factors for a fact-finding hearing if the "current condition" is "determined to be compensable" and the "worsened condition" claim subsequently materializes. To expedite the resolution of such potential disputes, the parties should consider developing the record regarding such potential issues at the "compensability" hearing. Under OAR 438-007-0027, Administrative Law Judges have the discretion to develop the record on such issues and issue an unappealable Own Motion Recommendation for the Board's future review. *James Stockwell*, 59 Van Natta 1641 (2007).

3. Including the determination of compensability in the definition of an "Own Motion claim" for a "worsened condition" in the Board's rules did not change the processing of medical service claims. In other words, the carrier remains responsible for processing medical service claims. ORS 656.262(1). If the carrier disputes compensability or the reasonableness and necessity of a medical service claim, the carrier must timely process that claim pursuant to ORS 656.245, ORS 656.260, and/or ORS 656.327.

G. The carrier is required to process the Own Motion claim after the "current condition" or medical services related to the "worsened condition" "have been determined compensable."

1. The carrier must either voluntarily reopen the claim or submit a "Carrier's Own Motion Recommendation" for or against reopening within 30 days after any compensability/responsibility dispute regarding medical services or a "current condition" related to a

² Jurisdiction over reasonableness and necessity of medical services is within the Director's jurisdiction. ORS 656.704(3)(b)(B).

“worsened condition” has “been determined compensable,” as defined under OAR 438-012-0001(3)(a) or (b). OAR 438-012-0030(1)

2. If, at the time this recommendation is due, a medical services dispute remains pending under ORS 656.260 or ORS 656.327, or the carrier disputes any of the remaining factors listed above in item (F-1) that are required to reopen the “worsened condition” claim, the carrier may recommend against reopening the claim on that basis.
3. In addition, if the carrier appeals the initial litigation order finding the medical services or “current condition” compensable, the carrier should include that basis for recommending against reopening in its “Carrier’s Own Motion Recommendation.” If the “initial litigation order” was an ALJ’s order, consistent with its longstanding practice, the Board would consolidate review of the two issues, deciding the compensability issue in its “regular” jurisdiction by means of an Order on Review and the “claim reopening” issue in its Own Motion jurisdiction by means of an Own Motion Order.

If the “initial litigation order” was an appealed Board order, the carrier should as soon as possible but within 30 days, submit a recommendation against claim reopening. In that situation, if the other factors listed above in item (F-1) were satisfied, the Board would likely issue a “claim reopening” order, relying on its appealed compensability order, provided that all other requirements for reopening are satisfied. Thereafter, the carrier could appeal the Board’s Own Motion “claim reopening” order and request the court to consolidate its review of the two appealed Board orders.³

4. If the “current condition” and/or medical services related to a “worsened condition” claim are never “determined to be compensable,” the carrier’s responsibility for Own Motion processing does not materialize. *Jimmie L. Taylor*, 58 Van Natta 75 (2006); *Marsha A. Lang*, 60 Van Natta 661 (2008) (applies *Taylor*).

H. Payment of temporary disability benefits on reopened Own Motion claims.

1. “Worsened condition” claims:

The requirements for payment of temporary disability benefits for claims reopened under ORS 656.278(1)(a) include at least the following. First, claimant must require (including

³ Injuries occurring before January 1, 1966 may result in a third type of claim that is under the Board’s Own Motion jurisdiction. In addition to “post-aggravation rights” new or omitted medical condition claims and “worsened condition” claims, a “pre-1966” injury claim may result in a medical service claim that is within the Board’s Own Motion jurisdiction. Specifically, medical service issues related to injuries occurring *before* January 1, 1966 are within the Board’s Own Motion jurisdiction, with a limited exception. See ORS 656.278(1)(c); OAR 438-012-0001(2)(c). This exception applies to medical service issues pertaining to injuries that occurred from August 5, 1959 through December 31, 1965 *and* resulted in an award of permanent total disability. Such claims are processed as claims for medical services under ORS 656.245. Or Laws 1959, ch 589, § 2; OAR 438-012-0020(7).

Processing of medical service claims related to “pre-1966” injury claims has not changed. However, all “post-aggravation rights” new or omitted medical condition claims and “worsened condition” claims, whether related to an injury occurring before or on or after January 1, 1966, are processed in the same manner, as described above.

a physician's recommendation for) hospitalization, surgery or other curative treatment (treatment that relates to or is used in the cure of diseases, tends to heal, restore to health, or to bring about recovery). Second, temporary disability benefits are payable from the date the attending physician authorizes temporary disability related to the hospitalization, surgery or other curative treatment (which may be the date the requisite treatment is recommended). Third, temporary disability benefits are payable under ORS 656.210, 656.212(2) and 656.262(4). *David L. Hernandez*, 56 Van Natta 2441 (2004) (temporary disability commences with surgery recommendation and attending physician authorization; applying *Mark A. Cavazos*, 55 Van Natta 3004 (2003)).

2. **“Post-aggravation rights” new/omitted medical condition claims:**

Entitlement to temporary disability benefits under ORS 656.278(1)(b) begins when the following requirements are satisfied. First, the claimant must require (including a physician's recommendation for) hospitalization, inpatient or outpatient surgery, or other curative treatment (treatment that relates to or is used in the cure of disease, tends to heal, restore to health, or to bring about recovery). Second, temporary disability benefits are payable from the date the attending physician authorizes temporary disability related to the hospitalization, surgery, or other curative treatment, which may be the date the requisite treatment is recommended. Third, temporary disability benefits are payable under ORS 656.210, ORS 656.212(2), and ORS 656.262(4). *Butcher v. SAIF*, 247 Or App 684, 689 (2012); *James M. Kleffner*, 57 Van Natta 3071 (2005); *David L. Hernandez*, 56 Van Natta 2441 (2004) (temporary disability commences with surgery recommendation and attending physician authorization; applying *Mark A. Cavazos*, 55 Van Natta 3004 (2003)).

3. Recommended requisite medical treatment is sufficient. As explained above in items (H-1 and H-2), the requisite medical treatment need not be scheduled or performed to establish that requirement for payment of temporary disability benefits. It is sufficient that the requisite treatment is recommended. See *Gary Leibel*, 60 Van Natta 759, 761 (2008) (temporary disability benefits payable from the date the attending physician authorized temporary disability related to a surgery, which was the date the requisite treatment was recommended); *David L. Hernandez*, 56 Van Natta 2441 (2004) (temporary disability commences with surgery recommendation and attending physician authorization; applying *Mark A. Cavazos*, 55 Van Natta 3004 (2003)).

4. Must be a member of the work force. A claimant may receive temporary disability benefits (as authorized by his or her attending physician) only for periods in which he or she was a member of the work force. ORS 656.005(30) (defining "worker" and providing that "'worker' does not include a person who has withdrawn from the work force" during the period for which temporary disability benefits are sought); ORS 656.278(1)(a)-(b), (2)(b); *Evalyn V. Stevens*, 59 Van Natta 1906, 1909 (2007); *Wendel P. Harrison*, 58 Van Natta 2474, 2476-77 (2006); *Rodney M. Waldrip*, 56 Van Natta 1516, 1518-19 (2004); *James J. Kemp*, 54 Van Natta 491, 503, 505 (2002).

Membership in the work force is determined by applying the factors in *Dawkins v. Pacific Motor Trucking*, 308 Or 254 (1989). In *Dawkins*, the court determined that a claimant is in the work force if he or she is: (1) engaged in regular gainful employment; or (2) not employed, but willing to work and is making reasonable efforts to obtain

employment; or (3) not employed, but willing to work and is not making reasonable efforts to obtain employment because a work-related injury has made such efforts futile. 308 Or at 258; *see* OAR 438-012-0035(3).

5. Entitlement to temporary disability benefits continues until the claimant is medically stationary, unless there is a statutory basis to terminate such benefits. *See* ORS 656.262(4), ORS 656.268(4)(a)-(d); ORS 656.278(1)(a)-(b); OAR 438-012-0035(5); *Donald B. Huege*, 55 Van Natta 1952, 1952-53 (2003); *Randy L. Goddard*, 55 Van Natta 874, 875-76, *adhered to as modified*, 55 Van Natta 1192 (2003).