OWN MOTION

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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. <u>For a "post-aggravation rights" new/omitted medical condition claim, "determined to be compensable" is defined as:</u>

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.

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

G. <u>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."</u>

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 "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

[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.

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(l)(a) include at least the following. First, claimant must require (including 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. <u>Recommended requisite medical treatment is sufficient</u>. 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. <u>Must be a member of the work force</u>. 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).