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COMMONLY ASKED OWN MOTION QUESTIONS

I. CLAIMANT QUESTIONS:

My claim is in Own Motion status - What is it?

For every compensable injury, a worker is given a 5-year time 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 whose aggravation rights have not expired.

How do I reopen my claim?

All Own Motion claims must first be directed to and processed by the carrier. An Own Motion claim is a written request to reopen a claim by or on behalf of a worker whose "aggravation rights" have expired. No formal form needs to be submitted; however, the request must contain sufficient information to identify the claimant and the claim. A claim may be reopened for:

1. A worsening of a previously accepted condition; and/or

- In cases involving a worsening of a previously accepted condition, a claimant may submit: (1) a written request for temporary disability; (2) a written request for claim reopening; or (3) a doctor's "aggravation form," medical report, or any other written document that indicates that his/her condition has worsened resulting in his/her inability to work and requiring hospitalization or inpatient or outpatient surgery, or other curative treatment prescribed in lieu of hospitalization that is necessary to enable him/her to return to work.

2. A new or omitted medical condition claim initiated after the claimant's "aggravation rights" have expired.

- In cases involving a "post-aggravation rights" new or omitted medical condition(s), the claimant or his or her attorney must clearly request formal written acceptance of that condition and inform the carrier of his/her request for Own Motion benefits. This request must clearly specify the condition(s) for which the claimant seeks acceptance.

If the carrier does not respond to an Own Motion claim, the claimant may submit his/her request for Own Motion benefits to the Board.

NOTE: A claim does not require reopening for payment of medical services, unless the injury occurred before January 1, 1966. *See* section regarding "Criteria Necessary for Reopening a Pre-1966 Injury Claim."

What types of claims are in Own Motion?

There are three types of claims in Own Motion:

(1) **Worsening**: a claim for a worsening of previously accepted condition(s) after expiration of aggravation rights;

(2) **New/Omitted Medical Condition**: a claim for a new or omitted medical condition initiated after expiration of aggravation rights ("post-aggravation rights" new or omitted medical condition claim); and

(3) **Pre-1966 Injury Claim**: a claim for benefits, including medical services, for a compensable injury occurring before January 1, 1966. *See* ORS 656.278(1)(a)-(c) (2001).

What is the criteria necessary for reopening a "worsened" Own Motion condition claim?

There are three requirements for the reopening of an Own Motion claim for a worsening of a previously accepted condition. All three requirements must be satisfied:

1. The worsening must result in the partial **or** total inability of the worker to work.
2. 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; **and**
3. 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).

How does a claimant meet the criteria necessary for reopening a "worsened" Own Motion condition claim?

Inability to work factor: A total or partial inability to work is sufficient to meet the requirement of "a worsening of a compensable injury that results in the inability of the worker to work." ORS 656.278(1)(a) (2001); *Fred Bonnell*, 55 Van Natta 2682 (2003); *James J. Kemp*, 54 Van Natta 491, 502 (2002). The "inability to work" issue is a medical question that must be addressed by medical evidence. *Stuart T. Valley*, 55 Van Natta 475, *on recon* 55 Van Natta 2521 (2003). In other words, a physician's release to modified work is sufficient.

- The "inability to work" requirement presents a medical question that must be addressed by medical evidence. *Kemp*, 54 Van Natta at 509. The Board cannot infer that a medical treatment/hospitalization will result in an inability to work. *SAIF v. Calder*, 157 Or App 224, 227-28 (1998) ("[t]he Board is not an agency with specialized medical expertise entitled to take official notice of technical facts within its specialized knowledge").

- Medical documentation that the worsening results in an "inability to work" might include a written statement from the claimant's physician that the surgery resulted in a partial or total inability to work, a physician's work release (or a release to modified work) due to the worsened condition, or a chart note from the physician regarding the claimant's partial or total inability to work due to the worsened condition. *See Reba F. Tibbetts*, 54 Van Natta 1432 (2002).

- In other words, to support a voluntary claim reopening or a recommendation for claim reopening, the carrier should seek a written report from a physician (*e.g.*, a "check-the-box" form, a concurrence report or a work release slip) which specifically addresses whether the current worsening has resulted in a *partial or total inability to work*, either before or after the proposed hospitalization, surgery, or other curative treatment. The claimant may also submit this documentation.

"Required Medical Treatment" factor: One of the following three types of medical treatment requirements must be met: (1) hospitalization (inpatient); (2) surgery (inpatient or outpatient); or (3) other curative treatment prescribed in lieu of hospitalization that is necessary to enable the injured worker to return to work.

This last type of treatment contains three requirements, all of which must be satisfied: (1) "curative treatment;" (2) "prescribed in lieu of hospitalization;" and (3) "that is necessary to enable the injured worker to return to work." *Larry D. Little*, 54 Van Natta 2536 (2002).

- Whether a recommended treatment includes hospitalization, surgery, or "other curative treatment prescribed in lieu of hospitalization that is necessary to enable the injured worker to return to work" presents a medical question that must be addressed by medical evidence. The Board cannot infer that a requisite treatment is recommended. *SAIF v. Calder*, 157 Or App at 227-28 ("[t]he Board is not an agency with specialized medical expertise entitled to take official notice of technical facts within its specialized knowledge").

- If the medical record is not clear, medical documentation should be submitted regarding whether the treatment at issue meets any of the treatment requirements under ORS 656.278(1)(a) (2001).

"Work Force" factor:

- In order to be entitled to temporary disability compensation, a claimant must be in the "work force" at the time of disability. For Own Motion claims, the "date of disability" is the date at which the "worsened" condition resulted in an inability to work and required the requisite medical treatment under ORS 656.278(1)(a) (2001). *Robert J. Simpson*, 55 Van Natta 3801 (2003); *Thurman M. Mitchell*, 54 Van Natta 2607 (2002).

- Generally, the following evidence is considered in determining whether a claimant was in the "work force" at the time of disability: copies of paycheck stubs; income tax forms; unemployment compensation records; a list of employers where the claimant looked for work

and dates of contact; a letter from a prospective employer; or a letter from a doctor stating that a work search would be futile because of the claimant's compensable condition for the period in question.

- The claimant must have also been willing to work at the time of disability. If the claimant was *not* working or actively seeking work at the time of disability and is asserting that the work injury made such efforts "futile", the claimant may prove willingness to work by submitting a sworn affidavit attesting to willingness to work during the relevant time period.

- Whether a work-related injury has made work search efforts futile is a medical question that must be answered by persuasive medical evidence. *Jack M. Sanders*, 55 Van Natta 1642, *on recon* 55 Van Natta 2019 (2003).

Note: The requirements to *pay* benefits on an open claim are different from the requirements to *reopen* a claim. A claim may meet the requirements for *reopening* and not meet the requirements for *payment* of benefits. *See* section regarding "Benefits Available on Open Own Motion Claim."

What is the criteria necessary for reopening a "post-aggravation rights" new or omitted medical condition claim?

There are only two requirements for claim reopening for a "post-aggravation rights" new or omitted medical condition claim:

1. The new or omitted medical condition claim is filed by the claimant (or his or her attorney) after the aggravation rights have expired on the initial claim; and

2. The new or omitted medical condition is accepted by the carrier or found compensable. ORS 656.267(3); ORS 656.278(1)(b) (2001).

NOTE: Unlike "worsened condition" claims under ORS 656.278(1)(a) (2001), there are no requirements for inability to work, requisite medical treatment or work force status to reopen a "post-aggravation rights" new/omitted medical condition claim under ORS 656.278(1)(b) (2001). *Norman R. Forney*, 56 Van Natta 257 (2004); *Charles Klutsenbeker*, 55 Van Natta 2244 (2003); *Duane L. Leafdahl*, 54 Van Natta 1796 (2002).

How does a claimant meet the criteria necessary for reopening a "post-aggravation rights" new/omitted medical condition claim?

ORS 656.267(1) (2001) provides that to initiate a "post-aggravation rights" new or omitted medical condition claim, the worker must clearly request formal written acceptance of a new or omitted medical condition from the carrier. The worker may initiate a new or omitted medical condition claim at any time. A claimant's attorney may make such a claim on the claimant's behalf. *Andria D. Costello*, 55 Van Natta 498, 501 fn 4 (2003).

However, such claims are **not** made by medical billings or by requests for authorization to provide (or actual provision of) medical services. The carrier is not required to accept every diagnosis, provided that the carrier's acceptance reasonably apprises the claimant and medical providers of the nature of the compensable conditions.

If the carrier chooses to accept the "post-aggravation rights" new/omitted medical condition, it must submit a "Modified Notice of Acceptance" pursuant to ORS 656.262(6) and OAR 436-060-0140. *See also* OAR 438-012-0024(1)(a), (2)(a).

Note: The requirements to *pay* benefits on an open claim are different from the requirements to *reopen* a claim. A claim may meet the requirements for *reopening* and not meet the requirements for *payment* of benefits. *See* section regarding "Benefits Available on Open Own Motion Claim."

What is the criteria necessary for reopening a pre-1966 injury claim?

A pre-1966 injury claim could involve a worsening of the compensable injury or a "post-aggravation rights" new or omitted medical condition claim. Under such circumstances, the requirements under those types of claim would apply, as explained above.

A pre-1966 injury claim could also involve a medical services claim. Under such circumstances, the carrier may provide for reasonable and necessary medical services as listed in OAR 438-012-0037.

There is an exception to the general rule that medical service claims for injuries occurring before 1966 are within the Board's Own Motion jurisdiction. Medical service claims relating to a compensable injury that occurred from August 5, 1959 through December 31, 1965, **and** resulted in an award of permanent total disability are not in Own Motion jurisdiction. Instead, such claims must be processed as claims for medical services under ORS 656.245. OAR 438-012-0020(5), (7).

How may a claimant respond when a carrier recommends against reopening of a "worsened" condition claim?

1. A carrier may contend that the claimant does not meet the criteria necessary for reopening on one or more of the following grounds:

- No inability to work; and/or no requisite medical treatment; and/or not in work force at the time of disability.
- **Response**: If the claimant disagrees with the recommendation, the claimant should submit written medical and/or lay documentation to refute the carrier's contentions. (See criteria necessary to meet these requirements as set forth above).

2. A carrier may contend that the current condition for which the claimant seeks reopening is not compensable:

- Carrier must also submit a denial issued pursuant to ORS 656.262. *Eva M. Tucker*, 55 Van Natta 2577 (2003).
- **Response**: The claimant should follow the instructions in the "appeals rights" on the denial. The claimant has 60 days from the date of the denial to request hearing.

3. A carrier may contend that it is not responsible for the current condition:

- Carrier must submit a denial issued pursuant to ORS 656.308(2). *Eva M. Tucker*, 55 Van Natta 2577 (2003).
- **Response**: The claimant should follow the instructions in the "appeals rights" on the denial. The claimant has 60 days from the date of the denial to request hearing.

4. A carrier may contend that the medical treatment is inappropriate for the claimant's worsened condition. If the carrier disputes the reasonableness and necessity of a medical service but does not request Director review, the claimant may request such a review to resolve the dispute. ORS 656.245, ORS 656.260, or ORS 656.327.

NOTE: If a claimant sends any document, including correspondence, to the Board, he or she must also send a copy to the carrier. OAR 438-012-0016.

How may claimant respond when a carrier recommends against reopening of a "post-aggravation rights" new or omitted medical condition claim?

1. If the carrier contends that the "post-aggravation rights" new/omitted medical condition is not compensable:

- The carrier must also issue a "Notice of Denial of Compensability of 'Post-Aggravation Rights' New Medical Condition or Omitted Medical Condition Claim" pursuant to OAR 438-012-0024(1)(b), (2)(b) and OAR 438-012-0070.
- **Response**: The claimant should follow the instructions in the "appeals rights" on the denial. The claimant has 60 days from the date of the denial to request hearing.

2. If the carrier contends that it is not responsible for the "post-aggravation rights" new/omitted medical condition:

- The carrier must also issue a "Notice of Denial of Responsibility of 'Post-Aggravation Rights' New Medical Condition or Omitted Medical Condition Claim" pursuant to OAR 438-012-0024(1)(b), (2)(b) and OAR 438-012-0075.
- **Response**: The claimant should follow the instructions in the appeals rights on the denial. The claimant has 60 days from the date of the denial to request hearing.

3. If the carrier contends that the "post-aggravation rights" new/omitted medical condition is encompassed within prior Notice(s) of Acceptance:

- The carrier must also issue a "Notice of Clarification in Response to 'Post-Aggravation Rights' New Medical Condition or Omitted Medical Condition Claim" pursuant to OAR 438-012-0024(1)(c), (2)(c) and OAR 438-012-0080.
- **Response**: The claimant should follow the instructions in the "appeals rights" on the notice. The claimant has 60 days from the date of the notice to request hearing.

4. If the carrier contends that the claimant has attempted to make a claim for a "post-aggravation rights" new/omitted medical condition claim, but has not met the requirements to perfect such a claim:

- The carrier must also issue a "Notice of Incomplete Claim in Response to 'Post-Aggravation Rights' New Medical Condition or Omitted Medical Condition" pursuant to OAR 438-012-0024(1)(d), (2)(d) and OAR 438-012-0085. *Robert M. Hadwen*, 56 Van Natta 485 (2004).
- **Response**: If the claimant intends on filing such a claim, he or she should send a written request to the carrier clearly requesting formal written acceptance of the specific condition(s). Such actions will perfect a claim for a "post-aggravation rights" new/omitted medical condition and the carrier will be required to process that claim. In the alternative, the claimant may follow the instructions in the "appeals rights" on the notice, which states that the claimant may file a request for Board review within 60 days from the date of the notice.

NOTE: If a claimant sends any document, including correspondence, to the Board, he or she must also send a copy to the carrier. OAR 438-012-0016.

What benefits are available on open Own Motion claims?

If the statutory requirements are satisfied, temporary disability benefits are available on open Own Motion claims. ORS 656.278(1)(a), (b) (2001). Vocational services are not available for any type of Own Motion claims. ORS 656.278(2)(a) (2001).

Requirements for temporary disability benefits are the same for both worsened compensable condition claims and "post-aggravation rights" new or omitted medical condition claims. These requirements include:

1. Attending physician's authorization of temporary disability benefits for the hospitalization, surgery or other curative treatment;

2. The claimant must qualify as a "worker" under ORS 656.005(30); and

3. Temporary disability benefits are paid in accordance with ORS 656.210, ORS 656.212(2) and ORS 656.262(4). ORS 656.278(1)(a) and (b) (2001); ORS 656.278(2)(b) (2001).

- Attending Physician must authorize temporary disability for the hospitalization, surgery or other curative treatment. Benefits are payable from the time the attending physician authorizes temporary disability benefits for the hospitalization, surgery or other curative treatment until the worker's condition becomes medically stationary. However, temporary

disability benefits can be terminated before the medically stationary date under certain circumstances pursuant to ORS 656.262(4). For example, temporary disability is not due for any period of time not authorized by the attending physician. ORS 656.262(4)(g).

- Attending Physician authorization must be contemporaneous. A retroactive time loss authorization is valid for a maximum period of 14 days prior to its issuance. ORS 656.262(4)(g); *Gladys Biggs*, 56 Van Natta 391 (2004).

- Claimant must qualify as a "worker." Benefits under ORS 656.278(1) (2001) do not include temporary disability benefits for periods during which the claimant does not qualify as a "worker" under ORS 656.005(30), which defines "worker" as a person "who engages to furnish services for a remuneration, subject to the direction and control of an employer[.]" ORS 656.278(2)(b) (2001).

- Temporary disability benefits are paid pursuant to ORS 656.210, 656.212(2), and 656.262(4). The various provisions for payment and termination of temporary disability benefits explicitly apply to Own Motion claims, including the requirement that the attending physician authorize temporary disability benefits and the limitation that retroactive authorization is valid for a maximum period of 14 days. ORS 656.278(1)(a), (b) (2001); OAR 438-012-0035(5)(d); *Kemp,* 54 Van Natta at 504.

Note: At claim closure, permanent disability benefits may be available for "post-aggravation rights" new or omitted medical condition claims. Such benefits are **not** available for worsened condition claims. *See* "Closures" section.

How are benefits paid in an open Own Motion claim?

The carrier is required to make the first payment of temporary disability compensation within 14 days from the date the carrier voluntarily reopens the claim or the date of an Own Motion order of the Board reopening the claim. OAR 438-012-0035(4).

"Prospective" temporary disability (benefits accruing from the date of a Board order) shall begin no later than 14 days from the date of the Board order. *Peter Voorhies,* 55 Van Natta 2613 (2003).

"Retroactive" temporary disability (benefits accruing prior to the date of the Board's order) shall be paid no later than 14 days from the date the Board order becomes final, that is, within 44 days from the date of issuance of the Board's order. *Peter Voorhies,* 55 Van Natta 2613 (2003).

What is a carrier's Own Motion Notice of Closure?

When the claimant's condition is medically stationary, the carrier shall close the claim by issuing a "Notice of Closure: Own Motion Claim" (Form 2066) to the claimant, claimant's attorney, if any, and the Workers' Compensation Division. OAR 438-012-0055.

What can a claimant do if he/she disagrees with an Own Motion Notice of Closure?

If a claimant disagrees with any portion of the Notice of Closure, he/she must file with the Board a request for Board review of the carrier's closure within 60 days after the mailing date of the closure (or within 180 days if the claimant establishes good cause for failing to meet the 60 day deadline). OAR 438-012-0060(2).

The request must be in writing, signed by the claimant or the claimant's attorney, and include the claimant's name and mailing address, a statement that Board review is requested and the reason(s) for the request for review, the name of the insurer, and a copy of the Notice of Closure (Form 440-2066). OAR 438-012-0060(1).

What issues may be disputed regarding the Own Motion Notice of Closure?

Issues that may arise from a review of carrier closure:

1. Medically stationary. "Medically stationary" means that no further material improvement would reasonably be expected from medical treatment, or the passage of time. ORS 656.005(17).

- Claimant bears the burden of proving that the compensable condition(s) was not medically stationary at claim closure. Berliner v. Weyerhaeuser Corp., 54 Or App 624 (1981).

- "Medically stationary" does not mean that there is no longer a need for continuing medical care. Maarefi v. SAIF, 69 Or App 527, 531 (1984).

- A claim is prematurely closed where a new surgical treatment is proposed and there has been no change in the compensable condition between the date of closure and the date of surgery. *Ernest W. Mercer*, 50 Van Natta 2354 (1998).

2. Entitlement to temporary disability benefits. A claimant may dispute the temporary disability benefits awarded, including rate of payment and/or dates awarded. *See* section "Benefits Available on Open Own Motion Claim" for requirements for payment of temporary disability benefits.

3. Entitlement to permanent disability benefits. Permanent disability benefits are only available for "post-aggravation rights" new or omitted medical conditions. *Goddard v. Liberty Northwest Ins. Corp.*, 193 Or App 238 (2004). Payment of permanent disability compensation is provided after application of the Director's standards under ORS 656.726. ORS 656.278(1)(b) (2001).

- ORS 656.278(2)(d) (2001) allows for additional permanent disability benefits for an injured body part that was subject to a prior award but prevents a duplicate award of permanent disability benefits by providing for deduction of that portion of permanent disability previously awarded for the injured body part. *Cory L. Nielsen*, 55 Van Natta 3199 (2003).

- Medical Arbiter: If the claimant objects to the impairment findings used to rate impairment for a "post-aggravation rights" new or omitted medical condition, he or she may request referral to a medical arbiter. *Edward A. Miranda,* 55 Van Natta 784 (2003).

What happens after a claimant requests Board review of an Own Motion Notice of Closure?

The Board notifies all parties that review has been requested. The carrier has 14 days after notification to submit to the Board, the claimant, and the claimant's attorney, if any, legible copies of all evidence pertaining to the claimant's compensable condition at closure. OAR 438-012-0060(3). This evidence would include, but is not limited to, all relevant medical reports, chart notes, and *all* litigation orders, Notices of Acceptance, Determination Orders, Orders on Reconsideration, Notices of Closure and worksheet(s). The carrier may also submit written arguments at that time.

The claimant may submit additional evidence and written arguments within 21 days from the mailing date of the carrier's evidence. OAR 438-012-0060(4). Thereafter, the Board will complete its review and issue its decision.

If the claimant objects to the impairment findings used to rate impairment for a "post-aggravation rights" new or omitted medical condition and requests a medical arbiter, the Board will issue an interim order that refers the matter to the Director to appoint a medical arbiter. After the medical arbiter process is complete, the Board will implement a supplemental briefing schedule, complete its review, and issue its decision.

What can a claimant do if he/she disagrees with an Own Motion Order or Voluntary Reopening?

1. Voluntary Reopening. If a claimant disputes a carrier's voluntary reopening, he or she may submit a written request to the Own Motion Board to review that reopening. OAR 438-012-0061.

2. Reconsideration. If a party disagrees with an Own Motion Order, the party may request reconsideration within 30 days after the mailing date (or within 60 days if the party establishes good cause for failing to meet the 30 day deadline). OAR 438-012-0065. The request for reconsideration should include the reason(s) why the party disagrees with the Board's decision, including any supporting documentation.

4. Judicial review. A petition for judicial review must be filed within 30 days from the date of the order. Instructions explaining how to file this appeal are printed on the Board's order. Pursuant to ORS 656.278(4):

> "The claimant has no right to appeal any order or award made by the board on its own motion, except when the order diminishes or terminates a former award. The employer may appeal from an order which increases the award."

Board may not provide advice; contact Ombuds Office for Oregon Workers.

The Workers' Compensation Board is an adjudicative body that resolves issues arising from "Own Motion" claims between claimants and carriers. Because of that role, the Board is not authorized to provide advice. Additional questions should be directed to the Ombuds office, whose job it is to assist injured workers in such matters. The Ombuds Office for Oregon Workers may be contacted, free of charge, at 1-800-927-1271, Spanish speaking at 1-800-843-8086, in the Salem area at (503) 378-3351, or at the following address:

DEPT OF CONSUMER & BUSINESS SERVICES
OMBUDS OFFICE FOR OREGON WORKERS
PO BOX 14480
SALEM, OR 97309-0405

II. CLAIM ADJUSTER QUESTIONS:

When does a carrier have notice of an Own Motion claim?

Worsened Condition. ORS 656.278(1)(a) (2001)

A carrier is deemed to have notice of an Own Motion claim for a "worsened" medical condition when it receives a document that reasonably apprises it that:

1. Temporary disability benefits are requested; **or**

2. Own Motion claim reopening is requested; **or**

3. A claimant's previously accepted condition(s) has worsened resulting in an inability to work (total or partial) and requiring hospitalization, surgery or other curative treatment prescribed in lieu of hospitalization that is necessary to enable claimant to return to work.

> *E.g.*, a request from claimant that he/she is seeking temporary disability benefits; a request from claimant that his/her claim be reopened; a medical document indicating that claimant is seeking medical treatment for a previously accepted condition which has resulted in an inability to work (total or partial) and requires one of the requisite medical treatments (this could be a Form 827 but no specific "aggravation" form is required). *See Redeena M. Monroe*, 55 Van Natta 3730 (2003).
>
> *See* OAR 438-012-0020(3)(a),(b).

"Post-Aggravation Rights" New/Omitted Medical Condition. ORS 656.278(1)(b) (2001)

A carrier is deemed to have notice of an Own Motion claim for a "post-aggravation rights" new and/or omitted medical condition claim when it receives from claimant (and/or his attorney) any document that clearly requests formal written acceptance of a "post-aggravation rights" new/omitted medical condition.

See OAR 438-012-0020(4).

Can a carrier voluntarily reopen a claim without Board involvement?

In the absence of a dispute regarding an Own Motion claim, a carrier can avoid the time and expense of preparing an Own Motion recommendation and producing an evidentiary record for presentation to the Board by merely voluntarily reopening the claim.

This voluntary reopening is accomplished by using a Form 3501 and following the instructions in WCD Bulletin No. 195 (Rev. 09/02/03). OAR 438-012-0030(5). A Form 3501 should be submitted to the Workers' Compensation Division (WCD). The carrier must not send Forms 3501 to the Workers' Compensation Board (WCB). Such voluntary reopening must occur within 90 days after receiving an Own Motion claim (if the date of injury is before January 1, 2002) or within 60 days (if the date of injury is on or after January 1, 2002). OAR 438-012-0030(1)(a), (2)(a).

How does a carrier know an Own Motion claim qualifies for reopening?

Worsened Condition Claims:

There are three requirements for the reopening of an Own Motion claim for a worsening of a previously accepted condition.

1. The worsening must result in a partial or total inability of the worker to work. *See* ORS 656.278(1)(a) (2001); *Fred Bonnell*, 55 Van Natta 2682 (2003). The "inability to work" issue is a medical question that must be addressed by medical evidence. *Stuart T. Valley*, 55 Van Natta 475, *on recon* 55 Van Natta 2521 (2003).

   E.g., a chart note from a physician indicating that claimant is either totally or partially incapacitated from work due to a worsening of the compensable condition(s); a doctor's note reflecting work restrictions (modified work/work limitations) due to the compensable condition(s); a doctor's work release form.

2. 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. ORS 656.278(1)(a) (2001).

3. The worker must be in the "work force" at the "date of disability" as defined under the criteria in *Dawkins v. Pacific Motor Trucking*, 308 Or 254 (1989). (Page 9 of the Carrier's Own Motion Recommendation form explains the *Dawkins* criteria.)

   Under the *Dawkins* criteria, a claimant is in the work force at the time of disability if he or she is: (1) engaged in regular gainful employment; or (2) not employed, but willing to work and is seeking work; or (3) not employed, but willing to work and is not seeking work because a work-related injury has made such efforts futile. *Dawkins*, 308 Or at 258.

   The "date of disability" for a worsened condition claim in Own Motion status is the date the condition worsened: (1) resulting in a inability to work, and (2) requiring the requisite medical treatment under ORS 656.278(1)(a) (2001). *Robert J. Simpson*, 55 Van Natta 3801 (2003); *Thurman M. Mitchell*, 54 Van Natta 2607 (2002).

"Post-Aggravation Rights" New/Omitted Medical Condition Claims:

There are only two requirements regarding claim reopening for a "post-aggravation rights" new or omitted medical condition claim.

1. The new or omitted medical condition claim must have been initiated after the expiration of the claimant's aggravation rights under ORS 656.273.

   E.g., a request from claimant (and/or his attorney) clearly requesting acceptance of a "post-aggravation rights" new/omitted medical condition. ORS 656.267(1); *Andria D. Costello*, 55 Van Natta 498, 501 fn 4 (2003).

2. The new or omitted medical condition must be accepted or found compensable. *See* ORS 656.267(1), (3) (2001); ORS 656.278(1)(b) (2001).

NOTE: Unlike "worsened condition" claims under ORS 656.278(1)(a) (2001), there are no requirements for inability to work, requisite medical treatment or work force status to reopen a "post-aggravation rights" new/omitted medical condition claim under ORS 656.278(1)(b) (2001). *Norman R. Forney*, 56 Van Natta 257 (2004); *Charles Klutsenbeker*, 55 Van Natta 2244 (2003); *Duane L. Leafdahl*, 54 Van Natta 1796 (2002).

Will a carrier receive reimbursement for temporary/permanent disability benefits paid if it voluntarily reopens claimant's Own Motion claim using Form 3501 or does it require a Board's Own Motion order?

Reimbursement for the payment of such benefits is available under ORS 656.625. Such reimbursement is available from the Reopened Claims Program to carriers who voluntarily reopen Own Motion claims pursuant to ORS 656.278. In other words, a Board order is not required for reimbursement under the statute. Because the Board's authority does not extend

to this reimbursement process, any questions regarding reimbursement should be directed to the Workers' Compensation Division (WCD), Self-Insurance, Registration, and Reimbursements Section, at 503-947-7057.

What does a carrier do if it does not want to voluntarily reopen the claim or there are disputes regarding claim reopening?

If the carrier chooses not to voluntarily reopen the claim, it must submit a written recommendation to the Board and provide a copy to claimant and claimant's attorney, if any. The carrier must also provide documentary evidence that a copy of the written recommendation and attachments was forwarded to claimant and claimant's attorney, if any. OAR 430-012-0030(1)(b), (2)(b). Examples of documentary evidence include doctor's reports, chart notes, a Form 827, claimant's written request for Own Motion benefits, claimant questionnaires, denial(s) or notice(s) issued in response to claimant's current request, and all other written evidence relied on to complete the Board's Own Motion Recommendation.

Is claim reopening (either by Board order or voluntarily by the carrier) necessary if claimant is only seeking medical benefits?

A claimant has lifetime rights to medical services for compensable conditions under ORS 656.245. For injuries occurring on or after January 1, 1966, if claimant is not seeking temporary disability compensation (and/or permanent disability benefits for a "post-aggravation rights" new/omitted medical condition claim), a carrier does not have to seek a Board order or voluntarily reopen a claim to provide claimant with medical services for the compensable injury.

For injuries occurring before January 1, 1966, Board's Own Motion jurisdiction over medical services remains unchanged, *i.e.,* the Board has jurisdiction in its Own Motion authority over such claims. Therefore, a carrier must either seek a Board order reopening the claim or voluntarily reopen the claim for the provision of the requested medical services. **Exception:** If the injury occurred from August 5, 1959 through December 31, 1965, and resulted in an award of permanent total disability, medical services are payable under ORS 656.245.

Does a carrier need to submit an Own Motion recommendation form even if the claimant would not qualify for temporary disability benefits?

Yes. If a carrier does not voluntarily reopen a claim, it must submit to the Board a written recommendation as to whether or not the claim should be reopened, in the form prescribed by the Board and accompanied by the required evidence supporting the recommendation. OAR 438-012-0030(1)(b) and (2)(b). The carrier must either voluntarily reopen the claim or submit a recommendation within 90 days (if the date of injury is before January 1, 2002) or within 60 days (if the date of injury is on or after January 1, 2002) after receiving an Own Motion claim. This requirement of an Own Motion recommendation applies even if the claimant would not qualify for temporary disability benefits; *e.g.*, claimant does not qualify as a "worker" under ORS 656.005(30).

How does a carrier close an Own Motion claim that has been reopened under ORS 656.278?

Pursuant to OAR 438-012-0055, when a carrier is in receipt of medical reports indicating that claimant's condition has become medically stationary, the carrier shall close the claim without the issuance of a Board order. The carrier shall issue a Form 2066 ("Notice of Closure: Own Motion Claim") to the claimant with copies to his/her attorney (if any) and the Workers' Compensation Division. The Form 2066 closure shall inform the claimant of the amount and duration of temporary disability compensation, the amount of any permanent disability award determined under ORS 656.278(1)(b) and (2)(d)(2001), and the medically stationary date. If the carrier has awarded permanent disability benefits, a copy of its worksheet must also be included.

If the claimant requests Board review of an Own Motion Notice of Closure, the Board will notify all parties that review has been requested. The carrier has 14 days after notification to submit to the Board, the claimant, and the claimant's attorney, if any, legible copies of all evidence pertaining to the claimant's compensable condition at closure. These materials should be arranged in chronological order, be numbered as exhibits, and submitted with an exhibit list. OAR 438-012-0060(3). This evidence would include, but is not limited to, all relevant medical reports, chart notes, and *all* litigation orders, Notices of Acceptance, Determination Orders, Orders on Reconsideration, Notices of Closure and worksheet(s). The carrier may also submit written arguments at that time. The claimant may submit additional evidence and written arguments within 21 days from the mailing date of the carrier's evidence. OAR 438-012-0060(4). The Board may refer a matter to the Hearings Division for an evidentiary hearing. OAR 438-012-0060(6).

III. HELPFUL TIPS IN COMPLETING AN OWN MOTION RECOMMENDATION FORM

Carrier's Own Motion Recommendation (Form 440-2806)

If a carrier does not voluntarily reopen the claim(s), it must submit to the Board a written recommendation on Form 440-2806 (09/2003/WCB) ("Carrier's Own Motion Recommendation") regarding whether the claim should be reopened, accompanied by the required evidence supporting the recommendation. OAR 438-012-0030(1), (2). This recommendation must be submitted within 90 days after receiving an Own Motion claim (if the date of injury is before January 1, 2002), or within 60 days (if the date of injury is on or after January 1, 2002). OAR 436-012-0030(1)(b), (2)(b).

This supporting evidence would include copies of all relevant documents that were considered in preparing the recommendation. Regarding "worsened" condition claims, this evidence would include, but is not limited to: medical reports/chart notes regarding inability to work and requisite medical treatment, and documentation regarding workforce status. Regarding "post-aggravation rights" new or omitted medical condition claims this evidence would include, but is

not limited to: copies of the claim acceptance(s), denial(s), Notices of Clarification and/or Notice of Incomplete Claim. A copy of claimant's retainer agreement, if any, should also be submitted. Those materials should be arranged in chronological order, be numbered as exhibits, and submitted with an exhibit list. A copy of the entire claim file is unnecessary.

NOTE: WCB Bulletin No. 1-2003 (eff. 9/1/03) explains how to fill out this form.

Section A of the Carrier's Own Motion Recommendation pertains to the Own Motion claim information.

Question A-13 seeks the date the current claim was received by the insurer – the carrier must submit a date-stamped copy of claimant's request or indicate which medical document triggered the carrier's Own Motion processing duties.

Question A-17 seeks a listing of all previously accepted conditions and copies of the Notices of Acceptance. [Practice Tip: If the claim was accepted prior to the carrier's obligation to issue a notice of acceptance, the carrier must clarify this in its response to this question.]

Question A-18 seeks a listing of all conditions for which claimant has clearly requested formal written acceptance. These conditions will also be reflected in the carrier's response to Question C-2 (see below).

Question A-19 seeks a listing of all conditions for which claimant is currently treating, but has not clearly requested formal written acceptance. These conditions will also be reflected in the carrier's response to C-7 and its Notice of Incomplete Claim (see below).

Section B of the Carrier's Own Motion Recommendation pertains to "worsened" condition claims.

Question B-1 – asks if claimant has made a claim for a "worsening" of a previously accepted condition (see above description of "worsened" condition claims).

Question B-2 – asks if claimant's current "worsening" has resulted in an "inability to work" (total or partial) (see above description of the requirements regarding an "inability to work"). A copy of the document demonstrating an inability to work must accompany the Own Motion Recommendation.

Question B-3 – asks if claimant's previously accepted condition(s) has worsened requiring hospitalization or (inpatient/outpatient) surgery or curative treatment prescribed in lieu of hospitalization that is necessary to enable claimant to return to work.

Medical Treatment (*See Larry D. Little*, 54 Van Natta 2536 (2002)):

The three qualifying medical treatments listed in ORS 656.278(1)(a) (2001) are:

1. "Surgery" is defined as an invasive procedure undertaken for a curative purpose that is likely to temporarily disable the worker.

   E.g., copies of medical records demonstrating a recommendation for surgery or request for authorization for surgery or a surgical report.

2. "Hospitalization" is defined as a nondiagnostic procedure that requires an overnight stay in a hospital or similar facility.

   E.g., copies of medical records demonstrating a recommendation for hospitalization or a hospital admittance form/discharge form.

3. "Curative treatment" must satisfy three elements: (a) 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); (b) prescribed in lieu of (in the place of or instead of) hospitalization; and (c) that is necessary (required or essential) to enable the injured worker to return to work. *Little*, 54 Van Natta at 2542, 2546.

   E.g., a doctor's recommendation for treatment which is "curative" (in the doctor's opinion) that is prescribed in lieu of a recommendation for hospitalization or the hospitalization itself, so that claimant can return to work.

   Question B-4 – asks if the carrier agrees that claimant is in the work force at the date of disability (See above description of the requirements regarding "work force").

   Question B-5 – asks if the carrier agrees that the current "worsened" condition is causally related to the previously accepted condition. If the carrier disagrees and disputes the compensability of the "worsened" condition, it must also issue a denial of compensability under ORS 656.262. *Eva M. Tucker*, 55 Van Natta 2577 (2003).

   Question B-6 – asks if the carrier agrees that it is responsible for the current "worsened" condition. If the carrier disagrees and disputes the responsibility for the "worsened" condition, it must also issue a denial of responsibility under ORS 656.308(2). *Eva M. Tucker*, 55 Van Natta 2577 (2003).

   Question B-7 – asks if the carrier agrees that the recommended medical treatment is appropriate for claimant's compensable condition. If the carrier disagrees, it must seek Director's review for the medical treatment under ORS 656.245, ORS 656.260 and/or ORS 656.327.

   Question B-8 – requires that the carrier respond by recommending for or against reopening.

Section C of the Carrier's Own Motion Recommendation pertains to "post-aggravation rights" new and/or omitted medical condition claims initiated on or after September 1, 2003. *Keith A. Broeckel*, 55 Van Natta 3572 (2003).

Question C-1 - asks if claimant has initiated a "post-aggravation rights" new/omitted medical condition claim.

If yes, the carrier must *only* answer questions C-2 through C-5 and C-8. (not C-6 and C-7).

Question C-2 - asks the carrier to list the new/omitted medical conditions. The response to this question must match the carrier's response to question A-18.

Question C-3 - asks whether the carrier agrees that the new/omitted medical conditions are causally related to the accepted injury. If the answer is yes, C-3 directs the carrier to submit a "Modified Notice of Acceptance" pursuant to ORS 656.262(6) and OAR 436-060-0140. *See also* OAR 438-012-0024(1)(a), (2)(a).

If the answer to C-3 is no, this question reminds the carrier of its obligation to issue a "Notice of Denial of Compensability of 'Post-Aggravation Rights' New Medical Condition or Omitted Medical Condition Claim" pursuant to OAR 438-012-0024(1)(b), (2)(b) and OAR 438-012-0070.

Question C-4 - asks whether the carrier agrees that it is responsible for the new/omitted medical conditions. If the answer is no, C-4 reminds the carrier of its obligation to issue a "Notice of Denial of Responsibility of 'Post-Aggravation Rights' New Medical Condition or Omitted Medical Condition Claim" pursuant to OAR 438-012-0024(1)(b), (2)(b) and OAR 438-012-0075.

Question C-5 - asks whether the carrier contends that new/omitted medical conditions that are being claimed are already encompassed in the prior Notice(s) of Acceptance. If the answer is yes, C-5 reminds the carrier of its obligation to issue a "Notice of Clarification in Response to 'Post-Aggravation Rights' New Medical Condition or Omitted Medical Condition Claim" pursuant to OAR 438-012-0024(1)(c), (2)(c) and OAR 438-012-0080.

Question C-8 - depending on the responses completed above, the carrier must notify the Board whether it recommends for or against the reopening of the "post-aggravation rights" new or omitted medical condition claim.

- **If the answer to question C-1 is no**, the carrier must *first* answer question C-6. (Do not answer questions C2-C5).

Question C-6 - asks whether the carrier contends that claimant has attempted to make a claim for a "post-aggravation rights" new/omitted medical condition claim, but has not met the requirements to perfect such a claim (See above

description of the requirements for making a "post-aggravation rights" new or omitted medical condition claim). ORS 656.267(1); ORS 656.278(1)(b) and OAR 438-012-0020(4).

If the answer is yes to question C-6, the carrier must *only* answer C-7, and not C-8.

Question C-7 - if the answer to question C-6 is yes, this question reminds the carrier of its obligation to issue a "Notice of Incomplete Claim Response to 'Post-Aggravation Rights' New Medical Condition or Omitted Medical Condition" pursuant to OAR 438-012-0024(1)(d), (2)(d) and OAR 438-012-0085.

If the answer to question C-6 is no, the carrier must go to Section "D" to complete the form. Answering "No" to questions C-1 and C-6 indicates that the claimant has not made or attempted to make a claim for a "post-aggravation rights" new or omitted medical condition.

Section D – pertains to Own Motion claims regarding injuries occurring prior to 1966. The rules regarding "worsened" condition claims and "post-aggravation rights" new/omitted medical conditions claims apply to these claims. If you have further questions regarding completing this section, refer to the Summary Sheet and Bulletin 1-2003.

IV. **HELPFUL TOOLS TO USE WHEN PROCESSING AN OWN MOTION CLAIM**

Own Motion Processing Checklist
Own Motion Flow Chart