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In the Matter of the Compensation of  
**DAVID L. DOWNING, Claimant**  
Own Motion No. 14-00047OM  
OWN MOTION ORDER  
Ransom Gilbertson Martin et al, Claimant Attorneys  
SAIF Legal Salem, Defense Attorneys

Reviewing Panel: Members Weddell and Johnson.

Claimant requests Own Motion relief, seeking temporary disability benefits for this reopened “post-aggravation rights” new medical conditions claim (“osteomyelitis, right knee; failed right knee replacement and amputation of right leg above the knee”). Stating that “it appears he is medically stationary,” claimant also seeks an “Own Motion Order setting forth his right to benefits,” including an award for the amputation of his leg. We interpret this as a request for an order awarding scheduled permanent partial disability (PPD). Based on the following reasoning, we award temporary disability benefits and deny claimant’s other requests as premature.

FINDINGS OF FACT<sup>1</sup>

On January 12, 1983, claimant compensably injured his right knee. The SAIF Corporation accepted a disabling injury, without identifying the accepted condition. (Ex. 4).

In March 1983, claimant underwent surgery (patellar femoral realignment, right knee). (Ex. 7). A June 30, 1986 Determination Order awarded 25 percent (37.5 degrees) scheduled PPD for loss of use or function of the right leg (knee). (Ex. 21C). Claimant’s aggravation rights expired on June 30, 1991.

On June 16, 1987, claimant underwent a patellar realignment (Maquet procedure) of the right knee. (Ex. 37-3). A March 14, 1988 Determination Order awarded an additional 15 percent (22.5 degrees) scheduled PPD, for a total award of 40 percent (60 degrees) scheduled PPD for loss of use or function of the right leg (knee). (Ex. 21F).

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<sup>1</sup> In addition to the record developed in WCB Case No. 14-00047OM, these findings are taken from the following source. Claimant initially requested a hearing regarding his request for relief concerning the reopened “post-aggravation rights” new medical conditions claim (“osteomyelitis, right knee; failed right knee replacement and amputation of right leg above the knee”). (WCB Case No. 14-01447). As a result, an Administrative Law Judge (ALJ) dismissed that hearing request for lack of jurisdiction. We have considered the record developed for that case in making these findings.

Subsequently, claimant underwent multiple right knee surgeries, including a patellectomy in May 1993 and a partial lateral meniscectomy in January 1998. (Ex. 37-3, -4). As a result of those surgeries, his Own Motion claim was reopened and subsequently closed for “worsened conditions” in June 1994 and July 1998, respectively. (Exs. 21G, 21H).

On September 14, 2001, claimant sustained a compensable injury to his *left* knee while working for a Washington employer (Claim No. Y171690). (Exs. 27A, 27E-1). Claimant received temporary disability benefits on that claim in November 2001, and from March 11, 2002 through January 15, 2011. (Ex. 197-3-7). As of January 16, 2011, he began receiving “total permanent disability” benefits on that Washington claim.<sup>2</sup> (Exs. 197-2, -31-33). In addition, claimant received vocational services on that claim in 2003, 2006, and 2007. Those services were terminated in 2003 and 2006 due to a worsening of claimant’s condition (*i.e.*, “medical instability”). (Exs. 27E-2, -18, 86A, 86B, 100A). In 2007, vocational services were terminated because of claimant’s inability to work or participate in retraining due to the work injury. (Ex. 110C).

On January 14, 2004, claimant returned to Dr. Sandefur for treatment of increased *right* knee pain, with instability and giving away. (Ex. 29). Dr. Sandefur released claimant from work as of that date, without limiting the work release to a specific time period or indicating any date that he could return to work. (Ex. 28).

On November 8, 2004, after a series of right knee injections failed to offer any relief, Dr. Sandefur recommended a right total knee arthroplasty (TKA). (Ex. 36). On December 19, 2004, Dr. Courogen examined claimant on behalf of SAIF and found that the proposed right TKA was reasonable and appropriate treatment, given the condition of claimant’s right knee and his previous multiple surgeries. (Ex. 37-8). Dr. Courogen noted that claimant was currently unemployed. (Ex. 37-5).

On February 22, 2005, Dr. Sandefur performed a left TKA, a right TKA, and an “arthroplasty right patella with tibial plateau eminence autograft.” (Ex. 39).

Subsequently, the right knee patellar autograft fractured and failed. (Ex. 41). On May 3, 2005, Dr. Sandefur performed a “patellectomy right knee with removal of failed patella utilizing tibial allograft.” (Ex. 42).

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<sup>2</sup> These monthly benefit payments, which began on January 16, 2011, were variously described as “total permanent disability,” “pension benefits,” and “totally disabled worker benefits.” (Exs. 197-2, -31-33).

Thereafter, claimant continued to have problems with his right knee, which repeatedly became infected and required extensive treatment. This treatment included intravenous antibiotics, arthroscopic “wash out” of the right knee, and repeat aspirations. (Exs. 43, 44, 47, 51). In July 2005, claimant required emergency room treatment for an infected prosthetic right knee. (Ex. 49).

By August 2005, Dr. Sandefur was considering removal of the right knee prosthesis due to claimant’s ongoing infection. (Ex. 53). On August 23, 2005, Dr. Sandefur performed surgery (“arthrotomy, right knee, with irrigation and debridement of right knee joint and exchange of polyethylene liner, right knee”) and noted that claimant was “disabled from his work injury.” (Exs. 55-1, 56-1).

Claimant continued to be treated for his right knee infection. (Exs. 57, 58). On October 31, 2005, Dr. Vigeland, a surgeon at OHSU, became the attending physician and noted that claimant’s work release authorization “continues.” (Ex. 60). Dr. Vigeland did not limit the work release to a specific time period or indicate any date that claimant could return to work. (*Id.*)

On November 1, 2005, Dr. Vigeland surgically removed the right TKA and replaced it with a “methylmethacrylate-coated femoral component with additional cement for stabilization of the knee.” (Ex. 61-1). He found “obvious osteomyelitis” in the tibia. (*Id.*)

After removal of the right TKA, claimant continued to require medical treatment, including hospitalizations, for his ongoing right knee infection and severe pain. Dr. Sandefur returned to his status as attending physician and provided ongoing care. (Exs. 64, 65, 66, 67, 70, 73, 87, 89, 91).

On April 25, 2006, following treatment of his right knee infection, claimant returned to Dr. Vigeland for implantation of a new TKA. (Exs. 96, 97). Claimant returned to Dr. Sandefur for follow-up care. (Exs. 99, 105, 107, 110).

On November 17, 2007, claimant was hospitalized for a recurrent right knee infection (“septic right artificial knee”). (Exs. 111, 112, 113). On November 19, 2007, Dr. Sandefur diagnosed an infected right TKA and performed surgery (“I&D of infected right total knee arthroplasty with polyethylene exchange”). (Exs. 115-2, 116-1). Dr. Sandefur continued to treat the right knee infection with prescription antibiotics and pain medication. (Ex. 120).

On February 11, 2008, claimant was treated in the emergency room for increased swelling and severe pain in the right knee. (Ex. 120-7). On February 18, 2008, Dr. Sandefur diagnosed a reinfected right TKA and discussed treatment options; *i.e.*, removing the entire prosthesis or trying again to wash out the knee joint with a polyethylene exchange, followed by IV antibiotic therapy. (Ex. 120-9). Claimant chose the latter option. (*Id.*)

On February 26, 2008, claimant was examined by Dr. Stark, an infectious disease specialist, on referral from Dr. Sandefur. Dr. Stark recommended a specific combination of antibiotics to treat claimant's right knee infection. (Ex. 122).

On February 27, 2008, Dr. Sandefur diagnosed an infected right TKA and performed surgery ("Irrigation and debridement of infected right total knee arthroplasty with polyethylene exchange"). (Ex. 124). Dr. Sandefur also noted that claimant was disabled. (Ex. 123-1). Following surgery, Dr. Sandefur continued to treat claimant's infection. (Exs. 125, 130).

On June 24, 2008, Dr. Sandefur surgically removed the infected right TKA and inserted a methylmethacrylate spacer. (Exs. 132, 133). Dr. Sandefur also noted that claimant was disabled. (Ex. 132-2). Following surgery, claimant continued with antibiotics. (Exs. 134, 135).

On September 2, 2008, after successful antibiotic treatment, Dr. Sandefur surgically implanted a new right TKA, with removal of the cemented spacer. (Exs. 136, 137). Dr. Sandefur also noted that claimant was disabled. (Ex. 136-2). On September 16, 2008, claimant required "arthroscopic incision and drainage" of the right knee due to recurrent infection. (Ex. 141). Thereafter, he was treated with IV antibiotics. (Exs. 142, 143).

On October 4, 2008, claimant dislocated his right TKA, which required a closed reduction and bracing. (Exs. 144, 145).

In November 2008, claimant began treating with Dr. Stoune for pain management and to wean him off some of the prescription pain medications. (Exs. 145-4, 146). In May 2009, Dr. Sandefur prescribed a custom-molded right knee brace in an effort to reduce swelling and improve stability. (Ex. 147-5). In December 2009, claimant again dislocated his right TKA, requiring closed reduction. (Ex. 148).

In January 2011, claimant fell, hyperflexing his right knee, which precipitated wound complications. (Exs. 154, 164-1, 165). In April and July 2011, claimant developed abscesses in the right knee that required surgical treatment. (Exs. 155, 156). On August 4, 2011, Dr. Sandefur expressed concern that this was a chronic infection in the right knee, which might require amputation or revision if it could not be suppressed with antibiotics. (Ex. 158-1).

On August 25, 2011, Dr. Sandefur opined that he was trying to keep the chronic knee infection suppressed with antibiotics, as recommended by the infectious disease physician. However, if the right knee became infected again, the options were to remove the components, use a cement spacer, and subsequently reimplant a “hinged knee prosthesis.” The other options were a knee fusion or an above-knee amputation. (Ex. 160).

In October 2011, claimant sought treatment at a wound care center and was advised that his primary problem was not his recurring ulceration but rather infected hardware. (Ex. 149-3). Claimant was referred to Dr. Menzner for his opinion on salvaging the limb because claimant was hesitant on proceeding with amputation or fusion, which were the recommendations previously made by an OHSU infectious disease specialist. (Ex. 149-1, -3).

On October 28, 2011, Dr. Menzner examined claimant and recommended an above-knee amputation. (Ex. 162-1). Claimant saw Dr. Gude at the wound care center, who diagnosed a “[r]ight anterior lower extremity pretibial ulceration with chronic underlying osteomyelitis and infected hardware status post knee replacement.” (*Id.*)

On November 10, 2011, claimant saw Drs. Ginnetti and Pelt, orthopedists, for a second opinion. (Ex. 164). They noted that he was “currently retired.” (Ex. 164-1). Due to the failures of the previous revisions, they did not consider claimant to be a candidate for further revision. They also noted that, with claimant’s significant bone loss, a fusion could be challenging and might leave residual infected bone. They considered an above-knee amputation (above the level of any osteomyelitis) would be the definitive treatment for claimant’s infection. (Ex. 164-4).

Also on November 10, 2011, claimant saw Dr. Rockwell, plastic surgeon, for a second opinion. (Ex. 165). He noted that claimant was disabled. Dr. Rockwell noted that Dr. Pelt did not consider that the right knee joint was salvageable and removing the prosthesis alone would have a low chance in resolving the osteomyelitis. If the knee was not salvageable, Dr. Rockwell had nothing more to offer.

On December 7, 2011, Dr. Sandefur performed a right above-knee amputation due to the chronically infected right TKA. (Ex. 168). Following this surgery, claimant developed an infection that required surgical treatment on February 7, 2012. (Ex. 176).

On March 6, 2012, Dr. Sandefur performed another surgery due to the infection (“revision amputation, right above-the-knee amputation with debridement and resection of scar tissue, capsular wall and bone new resection”). (Exs. 179, 180).

In April 2012, claimant was fitted for and began using a prosthesis. (Ex. 182-3, 183). In August 2013, Dr. Sandefur noted that claimant was having increased neuropathic pain due to the amputation and increased phantom leg pain. (Exs. 185-3, 188). He noted that if a change in medication did not control this pain, claimant may need to see a pain specialist. (Ex. 185-4).

On August 29, 2013, claimant requested that SAIF accept “post-aggravation rights” new medical conditions (“osteomyelitis, failed knee replacement and amputation of right leg above the knee”). (Ex. 187).

On October 31, 2013, Dr. Sandefur explained the change in claimant’s medication program that was being made to treat his neuropathic pain. (Ex. 188).

On December 3, 2013, Dr. Leggett examined claimant on behalf of SAIF. (Ex. 189). He reported that claimant’s stump had been in good condition for nearly two years, with the exception of occasional skin sores, and that his primary complaint was phantom pain. (Ex. 189-3). He noted that claimant was disabled and “now retired.” (Ex. 189-2). Dr. Leggett opined that the accepted right knee medial meniscus tear, dislocated patella or their sequelae were the major contributing cause of claimant’s consequential right knee osteomyelitis. (Ex. 189-5).

On December 16, 2013, SAIF accepted “post-aggravation rights” new medical conditions (“osteomyelitis, right knee; failed right knee replacement and amputation of right leg above the knee”). (Ex. 191). On March 26, 2014, SAIF voluntarily reopened claimant’s Own Motion claim for those conditions. (Ex. 196).

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CONCLUSIONS OF LAW AND OPINION

Temporary Disability

Claimant seeks temporary disability benefits for this reopened “post-aggravation rights” new medical conditions claim (“osteomyelitis, right knee; failed right knee replacement and amputation of right leg above the knee”). SAIF responds that claimant is not entitled to such benefits because he was not in the workforce at the date of disability. Based on the following reasoning, we find claimant entitled to temporary disability benefits.

Temporary disability compensation is not payable “for periods of time during which the claimant did not qualify as a ‘worker’ pursuant to ORS 656.005(30).”<sup>3</sup> ORS 656.278(2)(b); OAR 438-012-0035(2). A worker 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 making reasonable efforts to obtain employment; or (3) not employed, but willing to work, but not making reasonable efforts to obtain employment because a work-related injury has made such efforts futile. *Dawkins v. Pacific Motor Trucking*, 308 Or 254, 258 (1989).

Workforce status is determined at the time of disability. *Dawkins*, 308 Or at 258; *Weyerhaeuser Co. v. Kepford*, 100 Or App 410, 414, *rev den* 310 Or 71 (1990). The “date of disability” for the purposes of determining workforce status in an Own Motion claim for a “post-aggravation rights” new/omitted medical condition is the date the claimant’s condition: (1) resulted in a partial or total inability to work; and (2) required (including a physician’s recommendation for) hospitalization, inpatient or outpatient surgery, or other curative treatment. ORS 656.278(1)(b); *Butcher*, 247 Or App at 689-90; *Henry D. Desamais*, 64 Van Natta 652, 653 (2012). The “date of disability” is the date on which both of these factors are satisfied. *Arthur D. Kiser*, 57 Van Natta 1128, 1130 (2005); *Robert J. Simpson*, 55 Van Natta 3801 (2003).

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<sup>3</sup> ORS 656.005(30) defines “worker” and provides, in relevant part:

“‘Worker’ means any person \* \* \* who engages to furnish services for a remuneration, subject to the direction and control of an employer \* \* \*. For the purpose of determining entitlement to temporary disability benefits or permanent total disability benefits under this chapter, ‘worker’ does not include a person who has withdrawn from the workforce during the period for which benefits are sought.”

Here, on January 14, 2004, Dr. Sandefur, claimant's attending physician, released claimant from work due to his right knee condition. (Exs. 28, 29). This work release was "open-ended" or "ongoing" because it was not limited to a specific time period or the occurrence of a specific event. *See Willie V. Bell*, 62 Van Natta 1157, 1165 (2010) (work releases were "open-ended" or "ongoing" because they were not limited to a specific time period or the occurrence of a specific event). On November 8, 2004, Dr. Sandefur recommended right TKA surgery, which he performed on February 22, 2005. (Exs. 36, 39). However, that surgery was not for the "post-aggravation rights" new medical conditions ("osteomyelitis, right knee; failed right knee replacement and amputation of right leg above the knee"). Therefore, we do not find that it established the "date of disability" for the "post-aggravation rights" new medical conditions claim.

Instead, claimant's "date of disability" is established based on Dr. Vigeland's reports. On October 31, 2005, Dr. Vigeland was serving as claimant's attending physician and stated that claimant's work release authorization "continues." (Ex. 60). This work release was "open-ended" or "ongoing" because it was not limited to a specific time period or the occurrence of a specific event. *Bell*, 62 Van Natta at 1165.

Furthermore, on November 1, 2005, Dr. Vigeland surgically removed the right TKA and observed that there was "obvious osteomyelitis" in the tibia. (Ex. 61-1). Thus, Dr. Vigeland's surgery involved the right knee osteomyelitis and the failed right knee replacement, both of which were included in the "post-aggravation rights" new medical conditions ("osteomyelitis, right knee; failed right knee replacement and amputation of right leg above the knee"). Therefore, we conclude that, as of November 1, 2005, claimant's condition resulted in an inability to work and required surgery. Consequently, claimant's "date of disability" is November 1, 2005.

The relevant time period for which claimant must be in the workforce is the time before the "date of disability." *See generally SAIF v. Blakely*, 160 Or App 242 (1999); *Wausau Ins. Companies v. Morris*, 103 Or App 270 (1990); *see Benjamin A. Vandeman*, 66 Van Natta 1613, *recons*, 66 Van Natta 1762 (2014). Therefore, the November 2011 and December 2013 notations from Drs. Ginnett and Pelt and Dr. Leggett, respectively, regarding claimant's current "retirement" status are not relevant. (Exs. 164-1, 189-2).

The record establishes that, before the date of disability, *i.e.*, November 1, 2005, claimant was receiving temporary disability benefits under an accepted out-of-state claim incurred while working for another employer. Thus, claimant

has not voluntarily removed himself from the work force. To the contrary, he sustained another compensable injury while in the work force that prevented him from working at the time of his current disability. Under such circumstances, we conclude that claimant was in the work force at the date of disability. *See Bell*, 62 Van Natta at 1162 (while the claimant received temporary disability benefits due to a compensable injury, he remained in the workforce because he was unable to work due to a compensable injury); *David J. Funk*, 59 Van Natta 2878, 2879-80 (2007) (same reasoning applied where the claimant was receiving temporary disability benefits due to a compensable out-of-state injury).

Having found that claimant remained in the workforce, we proceed to address his entitlement to temporary disability benefits. There are several requirements for the payment of temporary disability benefits for a claim reopened under ORS 656.278(1)(b). 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).

In *Lederer v. Viking Freight, Inc.*, 193 Or App 226, *recons*, 195 Or App 94 (2004), the court held that ORS 656.262(4)(a) obligates the payment of temporary disability benefits when an objectively reasonable carrier would understand contemporaneous medical reports to signify an attending physician's contemporaneous approval excusing an injured worker from work. Because ORS 656.262(4) applies when determining eligibility to temporary disability benefits for claims in Own Motion status, *Lederer* has applicability for determining the adequacy of time loss authorization from an attending physician under ORS 656.278(1)(b). *Hernandez*, 56 Van Natta at 2448. Additionally, because this is an Own Motion claim, the temporary disability authorization must be "for the hospitalization, surgery or other curative treatment." ORS 656.278(1)(b).

Here, as addressed above, Dr. Vigeland continued claimant's work release as of October 31, 2005. (Ex. 60). Furthermore, this work release was "open-ended." We find that Dr. Vigeland's October 31, 2005 contemporaneous release from work constitutes a "contemporaneous medical confirmation that an employee cannot

perform his or her regular work and is excused from doing so.” *Lederer*, 193 Or App at 234. Moreover, this work release, which occurred the day before the November 1, 2005 surgery, satisfies the requirement of the attending physician’s authorization of temporary disability benefits “for the hospitalization, surgery or other curative treatment.” ORS 656.278(1)(b); *Gary M. Leibel*, 60 Van Natta 759 (2008) (temporary disability benefits awarded under ORS 656.278(1)(b) when attending physician recommended surgery and released the claimant to sedentary work); *Hernandez*, 56 Van Natta at 2449. (Ex. 61-1).

Accordingly, claimant is entitled to temporary disability compensation from October 31, 2005 until those benefits may be lawfully terminated.<sup>4</sup> See *Lowell Jaynes*, 57 Van Natta 718 (2005) (directing the carrier to pay temporary disability, then close reopened claim under OAR 438-012-0055, when condition becomes medically stationary); *Rodney M. Waldrup*, 56 Van Natta 1516, 1520 (2004) (attending physician’s ongoing authorization for modified work/time loss established entitlement to temporary disability benefits until the claimant’s condition became medically stationary).

Claimant’s counsel is awarded an “out-of-compensation” attorney fee equal to 25 percent of any increased temporary disability compensation created by this order, not to exceed \$1,500, payable directly to claimant’s attorney. ORS 656.386(4); OAR 438-015-0080(1).

### Medically Stationary / PPD

Claimant contends that “it appears he is medically stationary” and requests an “Own Motion Order setting forth his right to benefits,” including an award for the amputation of his leg. We interpret this as a request for an order awarding scheduled PPD for loss of use or function of claimant’s right leg (knee). Based on the following reasoning, we consider claimant’s request premature.

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<sup>4</sup> An injured worker is not entitled to receive any more than the statutory sum of benefits for a single period of temporary disability resulting from multiple disabling injuries. See *Fischer v. SAIF*, 76 Or App 656, 661 (1985); *Petshow v. Portland Bottling Co.*, 62 Or App 614 (1983), *rev den*, 296 Or 350 (1984); *David J. Funk*, 59 Van Natta 2878 (2007); *Michael C. Johnstone*, 48 Van Natta 761 (1996). Therefore, if any temporary disability compensation for a concurrent period between this claim and the Washington state claim is due claimant as a result of this order, SAIF may petition the Workers’ Compensation Division (WCD) for a pro rata distribution of payments. ORS 656.126(6); OAR 436-060-0020(7); *Funk*, 59 Van Natta at 2880 n 1 (the carrier may petition WCD for pro rata distribution of payments for any concurrent temporary disability compensation due between current claim and Washington state claim).

Because this claim is in Own Motion status, claim closure is governed by ORS 656.278, rather than ORS 656.268. *John S. Ross*, 57 Van Natta 1510, 1516 (2005). Under OAR 438-012-0055, when, as here, an Own Motion claim has been voluntarily reopened, the *carrier* must close that claim when “the medical reports indicate to the carrier that the claimant’s condition has become medically stationary.” Such claim closure is to be accomplished by the carrier in the first instance, “without the issuance of a Board order.” OAR 438-012-0055.<sup>5</sup> Therefore, to the extent that claimant requests that we issue an order awarding scheduled PPD, we decline that request. In any event, as addressed below, the record does not establish that claimant’s accepted “post-aggravation rights” new medical conditions (“osteomyelitis, right knee; failed right knee replacement and amputation of right leg above the knee”) are medically stationary. Therefore, claim closure is not appropriate at this time.

“Medically stationary” means that no further material improvement would reasonably be expected from medical treatment, or the passage of time. ORS 656.005(17). The issue of a claimant’s medically stationary status is primarily a medical question to be decided based on competent medical evidence. *Harmon v. SAIF*, 54 Or App 121, 125 (1981); *Thomas L. Bishop*, 55 Van Natta 147, 149 (2003).

Here, claimant cites no medical evidence regarding his medically stationary status, and we find none on this record. The closest evidence on this issue is a comment from Dr. Leggett, examining physician, who reported on December 3, 2013 that claimant’s stump had been in “good condition” for nearly two years, with the exception of occasional skin sores, and that his primary complaint was phantom pain. (Ex. 189-3). At that time, Dr. Sandefur was changing claimant’s medication program in an effort to treat his neuropathic pain. (Ex. 188).

We acknowledge that the term “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). Nevertheless, considering the extensive medical history previously recounted concerning claimant’s right TKA and his accompanying complications, we do not find that an examining physician’s isolated reference to claimant’s stump being in “good condition” to be sufficient to reach a conclusion

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<sup>5</sup> We have the authority to direct a carrier to close an Own Motion claim. See *Glen G. Lovitt*, 64 Van Natta 1046 (2012) (where unrebutted medical evidence established that the reopened “post-aggravation rights” new/omitted medical conditions were medically stationary, Board directed the carrier to close the Own Motion claim under OAR 438-012-0055).

that his new medical conditions have reached a stage where no further material improvement is reasonably expected. Consequently, the record does not establish that the aforementioned conditions are medically stationary.

Accordingly, the prerequisite for claim closure has not been satisfied. OAR 438-012-0055. Instead, SAIF must continue to process the claim and provide benefits in accordance with law, including payment of temporary disability compensation as addressed above. When all of claimant's conditions are medically stationary and there is sufficient information to determine permanent disability, SAIF shall close the claim pursuant to OAR 438-012-0055, including the payment of permanent disability compensation, if any, determined to be due under ORS 656.278(1)(b) and (2)(d) for the new medical conditions.

**IT IS SO ORDERED.**

Entered at Salem, Oregon on January 14, 2015