

Carrier's Own Motion Recommendation

Notice to Claimant

The Workers' Compensation Board will review this recommendation. Copies of all evidence considered by the carrier will be sent to the Board and to you. **If you disagree with the carrier's recommendation(s), it is recommended that you obtain an attorney. You may have an attorney of your choice, whose fee will be limited to a percentage of any additional compensation you may receive.** In addition, you may contact the Workers' Compensation Ombudsman, whose job it is to assist injured workers about workers' compensation matters: Workers' Compensation Ombudsman, P.O. Box 14480, Salem, OR 97309-0405. Phone (503) 378-3351 or 1-800-927-1271 (V/TTY) (within the State of Oregon).

You may submit your written position and/or additional evidence. If you send the Board additional material, please include a cover letter listing claim number and date of injury identified at items A-10 and A-11 on page 4 of this form. A copy of any material you submit to the Board **must** also be sent to the carrier at the address given at item A-3 on page 4 of this form.

To be considered, any material must be submitted within 14 days after your receipt of this recommendation form. The Board's mailing address is: Own Motion Unit, Workers' Compensation Board, 2601 25th St. SE Ste. 150, Salem, OR 97302-1282.

NOTE: (1) If your Own Motion claim is based on a worsening of your compensable injury (that is, your previously accepted condition(s)), the claim is eligible to be reopened only if there is a worsening of your compensable injury that: (a) results in a partial or total inability for you to work; (b) requires hospitalization or inpatient or outpatient surgery, or other curative treatment prescribed in lieu of hospitalization that is necessary to enable you to return to work; and (c) you are in the work force at the time of disability. [If the carrier contends that you were not in the work force at the time of disability, it must send you a copy of page 9 of this form, which explains the work force requirements]. If these three requirements are satisfied, the claim qualifies for reopening for the payment of benefits.

Benefits on a reopened "worsened condition" claim may include temporary disability compensation from the time your attending physician authorizes temporary disability compensation for the hospitalization, surgery or other curative treatment until your condition becomes medically stationary.

(2) If your Own Motion claim is based on a new medical condition or an omitted medical condition, it is eligible to be reopened only if: (a) you clearly request formal written acceptance from the carrier of the new/omitted medical condition; and (b) the carrier formally accepts the new/omitted medical condition or the condition is found compensable through litigation. If these two requirements are satisfied, the claim qualifies for reopening for the payment of benefits.

Benefits on a reopened new/omitted medical condition claim may include: (a) temporary disability compensation from the time your attending physician authorizes temporary disability compensation for the hospitalization, surgery or other curative treatment until your condition becomes medically stationary; and/or (b) permanent disability benefits.

If you need further assistance in this matter, please contact the Own Motion Coordinator at (503) 378-3308 or 1-877-311-8061 (within the State of Oregon).

Instructions to the Carrier

The carrier must process as a request for Own Motion relief under ORS 656.278 any claim that reasonably notifies it of: (1) medical services, worsened condition(s), and/or "post-aggravation rights" new/omitted medical condition(s) where the date of injury is before January 1, 1966 (OAR 438-012-0020(3), (4), (5); OAR 438-012-0030)); (2) worsening of a compensable injury which is filed after the expiration of aggravation rights under ORS 656.273(4) (OAR 438-012-0020(3); OAR 438-012-0030)); and/or (3) new or omitted medical condition(s) filed after the expiration of aggravation rights under ORS 656.273(4) (OAR 438-012-0020(4); OAR 438-012-0030)). Claims for medical services where the date of injury is on or after January 1, 1966 must be processed under ORS 656.245.

The carrier is not required to submit a written recommendation to the Board if it voluntarily reopens the claim under ORS 656.278(5) to provide benefits allowable under ORS 656.278. In addition, pursuant to ORS 656.625, a carrier's voluntary claim reopening under ORS 656.278 qualifies the carrier for reimbursement from the Reopened Claims Program. However, if the carrier voluntarily reopens the claim under ORS 656.278(5), it **must** submit a Form 3501 to the Workers' Compensation Division, with copies to claimant and claimant's attorney (if any). If the date of injury for the original claim is before January 1, 2002, the carrier must, within 90 days of receipt of claimant's written request for Own Motion relief, either: (1) voluntarily reopen the claim (Form 3501); or (2) submit its written recommendation, with supporting documentation, to the Board at the address given above. OAR 438-012-0030(1). If the date of injury for the original claim is on or after January 1, 2002, the carrier must, within 60 days of receipt of claimant's written request for Own Motion relief, either: (1) voluntarily reopen the claim (Form 3501); or (2) submit its written recommendation, with supporting documentation, to the Board at the address given above. OAR 438-012-0030(2).

If the carrier chooses not to voluntarily reopen the claim, it must send claimant and claimant's attorney, if any, a copy of its completed Carrier's Own Motion Recommendation, including copies of any material it submits with this form. The carrier must provide documentary evidence that a copy of the written recommendation and attachments was forwarded to claimant and claimant's attorney, if any.

If the carrier answers "NO" to items B-5 – B-7 on page 5 of this form, the carrier must submit a separate denial of medical services under ORS 656.262, and/or a denial of responsibility under ORS 656.308(2), and/or a request for Director review of medical treatment under ORS 656.245, ORS 656.260, and/or ORS 656.327.

If the carrier answers “NO” to item B-4 on page 5 or item D-10 on page 7 or of this form, the carrier must also send page 9 of this form to claimant.

If the carrier answers “YES” to items C-3 and/or D-17 (on pages 6 and 8, respectively, of this form), the carrier must submit a copy of the “Modified Notice of Acceptance” (OAR 438-012-0024(1)(a), (2)(a)).

If the carrier answers “NO” to any of items C-3 – C-4 and/or D-17 – D-18 (on pages 6 and 8, respectively, of this form), the carrier must submit the appropriate “notice” regarding each negative response: (1) Notice of Denial of “Post-Aggravation Rights” New Medical Condition or Omitted Medical Condition Claim (OAR 438-012-0024(1)(b), (2)(b); OAR 438-012-0070)); and/or (2) Notice of Denial of Responsibility for “Post-Aggravation Rights” New Medical Condition or Omitted Medical Condition Claim (OAR 438-012-0024(1)(b), (2)(b); OAR 438-012-0075)).

If the carrier answers “YES” to items C-5 and/or D-19 (on pages 6 and 8, respectively, of this form), the carrier must submit a Notice of Clarification in Response to “Post-Aggravation Rights” New Medical Condition or Omitted Medical Condition Claim (OAR 438-012-0024(1)(c), (2)(c); OAR 438-012-0080)).

If the carrier answers “YES” to items C-6 – C-7 and/or D-20 – D-21 (on pages 6 and 8, respectively, of this form), the carrier must submit a Notice of Incomplete Claim in Response to “Post-Aggravation Rights” New Medical Condition or Omitted Medical Condition Claim (OAR 438-012-0024(1)(d), (2)(d); OAR 438-012-0085)).

The carrier may reproduce the “Carrier’s Own Motion Recommendation” form as a word-processing document only if the product exactly reproduces all of the data fields and text on the Board’s document (Form 440-2806, eff. 09/01/03).

The carrier must submit legible copies of all documents that are relevant and material to the matters in dispute, together with an index. These documents shall include copies of all relevant medical reports concerning hospitalization, surgery, or other curative treatment prescribed in lieu of hospitalization that is necessary to enable claimant to return to work. These documents shall be arranged in chronological order and numbered in the lower right corner of each page, beginning with the document of earliest date, and preceded by the designation “Ex.” Pagination of multiple page documents shall be designated by a hyphen followed by the page number; *e.g.*, page 2 of document 3 shall be designated “Ex. 3-2.” The index shall include the document numbers, description of each document, author, number of pages, and date of the document.

SECTION A: CLAIM INFORMATION (Questions A-1 through A-19)

CARRIER INFORMATION.	
A-1. Carrier:	
A-2. Claims Examiner:	
A-3. Carrier Mailing Address and Phone Number:	
A-4. Date Recommendation Form Mailed:	
CLAIMANT INFORMATION.	
A-5. Claimant's Name (First, MI, Last):	
A-6. Claimant's Complete Current Address:	
A-7. Claimant's SSN:	
A-8. Claimant's Attorney (If represented, submit a copy of the Retainer Agreement).	
A-9. Claimant's Attorney's Address	
CLAIM INFORMATION.	
A-10. Claim Number:	
A-11. Date of Injury:	
A-12. Employer-at-Injury: Name and Address:	
A-13. Date the current claim was received by carrier (Submit a date-stamped copy of the written claim/request).	Date:
A-14. Date of the first claim closure	Date:
A-15. Date aggravation rights expired	Date:
A-16. Date of last closure pursuant to ORS 656.268	Date:
A copy of the <u>first</u> Determination Order or Notice of Closure shall be submitted. If the claim was first accepted as a "nondisabling claim," a copy of the Notice of Acceptance shall be submitted. A copy of the <u>last</u> Determination Order or Notice of Closure issued pursuant to ORS 656.268 shall also be submitted.	
A-17. Conditions accepted prior to current request for Own Motion relief. (List below).	
a. Condition:	Date Accepted:
b. Condition:	Date Accepted:

A-18. Currently Claimed Condition(s) – Condition(s) for which claimant has made a claim under this request for Own Motion relief. (List below).	
Currently Claimed Condition(s):	Date Claimed:
A-19. Current Condition(s) – Condition(s) other than the accepted condition(s) for which claimant is currently treating but has not made a claim. (List below).	
Current Condition(s):	

SECTION B: “WORSENERD CONDITION” CLAIM SUBMITTED AFTER EXPIRATION OF AGGRAVATION RIGHTS.

(See page 3 for explanation of supporting documentation required).

Yes	No	
<input type="checkbox"/>	<input type="checkbox"/>	B-1: Has claimant submitted a claim related to an injury that occurred on or after 1/1/1966 for a “worsened condition” for which the aggravation rights have expired? ORS 656.278(1)(a); OAR 438-012-0020(3). (If yes, complete all questions in Section B, then proceed to Section C). (If no, proceed to Section C).
<input type="checkbox"/>	<input type="checkbox"/>	B-2: Does claimant’s current “worsened condition” result in a partial or total inability of claimant to work? ORS 656.278(1)(a).
<input type="checkbox"/>	<input type="checkbox"/>	B-3: Does claimant’s current “worsened condition” require hospitalization or inpatient or outpatient surgery or other curative treatment prescribed in lieu of hospitalization that is necessary to enable claimant to return to work? ORS 656.278(1)(a).
<input type="checkbox"/>	<input type="checkbox"/>	B-4: The carrier agrees that claimant was in the work force at the time of disability. If no, attach an explanation for that position, with supporting material, and send a copy of page 9 to claimant.
<input type="checkbox"/>	<input type="checkbox"/>	B-5: The carrier agrees that the current “worsened condition” is causally related to the accepted condition. If no, submit a copy of any denial issued pursuant to ORS 656.262.
<input type="checkbox"/>	<input type="checkbox"/>	B-6: The carrier agrees that it is responsible for the current “worsened condition.” If no, submit a copy of any denial issued pursuant to ORS 656.308(2).
<input type="checkbox"/>	<input type="checkbox"/>	B-7: The carrier agrees that the hospitalization, surgery, or other curative treatment prescribed in lieu of hospitalization that is necessary to enable claimant to return to work is reasonable and necessary. If no, submit a copy of any request for Director review of medical treatment pursuant to ORS 656.245, ORS 656.260, and/or ORS 656.327.
<input type="checkbox"/>	<input type="checkbox"/>	B-8: RECOMMENDATION: Reopen “Worsened Condition” Claim. (Indicate “yes” if the carrier recommends reopening the “worsened condition” claim). (Indicate “no” if the carrier recommends against reopening the claim).

SECTION C: “POST-AGGRAVATION RIGHTS” NEW AND/OR OMITTED MEDICAL CONDITION CLAIM.
(See page 3 for explanation of supporting documentation required).

Yes	No	
<input type="checkbox"/>	<input type="checkbox"/>	<p>C-1: Has claimant submitted a claim related to an injury that occurred on or after 1/1/1966 for a compensable new medical condition or omitted medical condition and the claim was initiated after expiration of aggravation rights? ORS 656.278(1)(b); OAR 438-012-0020(4). (If yes, complete questions C-2 through C-5, and C-8). (If no, proceed to question C-6).</p>
<p>C-2: List the claimed new/omitted medical condition(s).</p>		
<input type="checkbox"/>	<input type="checkbox"/>	<p>C-3: The carrier agrees that the “post-aggravation rights” new/omitted medical condition(s) claimed is/are causally related to the accepted condition(s). If yes, submit a copy of the “Modified Notice of Acceptance” pursuant to ORS 656.262(6) and OAR 436-060-0140. See OAR 438-012-0024(1)(a), (2)(a). If no, submit a copy of the “Notice of Denial of ‘Post-Aggravation Rights’ New Medical Condition or Omitted Medical Condition Claim.” See OAR 438-012-0024(1)(b), (2)(b); OAR 438-012-0070.</p>
<input type="checkbox"/>	<input type="checkbox"/>	<p>C-4: The carrier agrees that it is responsible for the “post-aggravation rights” new/omitted medical condition(s) claimed. If no, submit a copy of “Notice of Denial of Responsibility for ‘Post-Aggravation Rights’ New Medical Condition or Omitted Medical Condition Claim.” See OAR 438-012-0024(1)(b), (2)(b); OAR 438-012-0075.</p>
<input type="checkbox"/>	<input type="checkbox"/>	<p>C-5: The carrier contends that no acceptance of the claim is required because the previously issued Notice(s) of Acceptance reasonably apprises claimant and the medical providers of the nature of the compensable condition(s). If yes, submit a copy of “Notice of Clarification in Response to ‘Post-Aggravation Rights’ New Medical Condition or Omitted Medical Condition Claim.” See OAR 438-012-0024(1)(c), (2)(c); OAR 438-012-0080.</p>
<input type="checkbox"/>	<input type="checkbox"/>	<p>C-6: Claimant purported to make a claim for a “post-aggravation rights” new or omitted medical condition claim. ORS 656.278(1)(b); OAR 438-012-0020(4). (If yes, proceed to question C-7). (If no, proceed to Section D).</p>
<input type="checkbox"/>	<input type="checkbox"/>	<p>C-7: The carrier contends that no acceptance or denial of the purported “post-aggravation rights” new or omitted medical condition claim is required because the document received by the carrier from claimant does not clearly request formal written acceptance of a new or omitted medical condition. If yes, submit a copy of “Notice of Incomplete Claim Response to ‘Post-Aggravation Rights’ New Medical Condition or Omitted Medical Condition Claim.” See OAR 438-012-0024(1)(d), (2)(d); OAR 438-012-0085. Go to Section D.</p>
<input type="checkbox"/>	<input type="checkbox"/>	<p>C-8: RECOMMENDATION: Reopen the “Post-Aggravation Rights” New/Omitted Condition Claim. (Indicate “yes” if the carrier recommends reopening the “post-aggravation rights” new/omitted medical condition claim). (Indicate “no” if the carrier recommends against reopening the claim).</p>

SECTION D: PRE-1966 INJURY CLAIMS.

(See page 3 for explanation of supporting documentation required).

Yes	No	
Pre-1966 Medical Services Claim.		
<input type="checkbox"/>	<input type="checkbox"/>	D-1: Has claimant submitted a request for medical services for a work injury that occurred before 1966? ORS 656.278(1)(c); OAR 438-012-0020(5). (If yes, complete questions D-2 – D-6). (If no, proceed to question D-7).
D-2: List medical services:		
<input type="checkbox"/>	<input type="checkbox"/>	D-3: The carrier agrees that the requested medical services are compensably related to the accepted condition.
<input type="checkbox"/>	<input type="checkbox"/>	D-4: The carrier agrees that it is responsible for the requested medical services.
<input type="checkbox"/>	<input type="checkbox"/>	D-5: The carrier agrees that the requested medical services are reasonable and necessary for the accepted condition.
<input type="checkbox"/>	<input type="checkbox"/>	D-6: RECOMMENDATION: Reopen Pre-1966 Medical Services Claim. (Indicate “yes” if the carrier recommends reopening the pre-1966 medical services claim). (Indicate “no” if the carrier recommends against reopening the claim).
Pre-1966 “Worsened Condition” Claim.		
<input type="checkbox"/>	<input type="checkbox"/>	D-7: Has claimant submitted a claim for a “worsened condition” related to a work injury that occurred before 1966? ORS 656.278(1)(a); OAR 438-012-0020(3). (If yes, complete questions D-8 – D-14). (If no, proceed to question D-15).
<input type="checkbox"/>	<input type="checkbox"/>	D-8: Does claimant’s current “worsened condition” result in a partial or total inability of claimant to work? ORS 656.278(1)(a).
<input type="checkbox"/>	<input type="checkbox"/>	D-9: Does claimant’s current “worsened condition” require hospitalization or inpatient or outpatient surgery or other curative treatment prescribed in lieu of hospitalization that is necessary to enable claimant to return to work? ORS 656.278(1)(a).
<input type="checkbox"/>	<input type="checkbox"/>	D-10: The carrier agrees that claimant was in the work force at the time of disability. If no, attach an explanation for that position, with supporting material, and send a copy of page 9 to claimant.
<input type="checkbox"/>	<input type="checkbox"/>	D-11: The carrier agrees that the current “worsened condition” is causally related to the accepted condition.
<input type="checkbox"/>	<input type="checkbox"/>	D-12: The carrier agrees that it is responsible for the current “worsened condition.”
<input type="checkbox"/>	<input type="checkbox"/>	D-13: The carrier agrees that the hospitalization, surgery, or other curative treatment prescribed in lieu of hospitalization that is necessary to enable claimant to return to work is reasonable and necessary.
<input type="checkbox"/>	<input type="checkbox"/>	D-14: RECOMMENDATION: Reopen Pre-1966 “Worsened Condition” Claim. (Indicate “yes” if the carrier recommends reopening the pre-1966 “worsened condition” claim). (Indicate “no” if the carrier recommends against reopening the claim).

Yes	No	Pre-1966 “Post-Agravation Rights” New/Omitted Medical Condition Claim.
<input type="checkbox"/>	<input type="checkbox"/>	<p>D-15: Has claimant submitted a claim for a “post-aggravation rights” new or omitted medical condition related to a work injury that occurred before 1966? ORS 656.278(1)(b); OAR 438-012-0020(4). (If yes, complete questions D-16 through D-19, and D-22). (If no, proceed to question D-20).</p>
		D-16: List the claimed new/omitted medical condition(s).
<input type="checkbox"/>	<input type="checkbox"/>	<p>D-17: The carrier agrees that the “post-aggravation rights” new/omitted medical condition(s) claimed is/are causally related to the accepted condition(s). If yes, submit a copy of the “Modified Notice of Acceptance” pursuant to ORS 656.262(6) and OAR 436-060-0140. See OAR 438-012-0024(1)(a), (2)(a). If no, submit a copy of the “Notice of Denial of ‘Post-Agravation Rights’ New Medical Condition or Omitted Medical Condition Claim.” See OAR 438-012-0024(1)(b), (2)(b); OAR 438-012-0070.</p>
<input type="checkbox"/>	<input type="checkbox"/>	<p>D-18: The carrier agrees that it is responsible for the “post-aggravation rights” new/omitted medical condition(s) claimed. If no, submit a copy of “Notice of Denial of Responsibility for ‘Post-Agravation Rights’ New Medical Condition or Omitted Medical Condition Claim.” See OAR 438-012-0024(1)(b), (2)(b); OAR 438-012-0075.</p>
<input type="checkbox"/>	<input type="checkbox"/>	<p>D-19: The carrier contends that no acceptance of the claim is required because the previously issued Notice(s) of Acceptance reasonably apprises claimant and the medical providers of the nature of the compensable condition(s). If yes, submit a copy of “Notice of Clarification in Response to ‘Post-Agravation Rights’ New Medical Condition or Omitted Medical Condition Claim.” See OAR 438-012-0024(1)(c), (2)(c); OAR 438-012-0080.</p>
<input type="checkbox"/>	<input type="checkbox"/>	<p>D-20: Claimant purported to make a claim for a “post-aggravation rights” new or omitted medical condition related to a work injury that occurred before 1966. ORS 656.278(1)(b); OAR 438-012-0020(4). (If yes, complete question D-21). (If no, stop here).</p>
<input type="checkbox"/>	<input type="checkbox"/>	<p>D-21: The carrier contends that no acceptance or denial of the purported pre-1966 “post-aggravation rights” new or omitted medical condition claim is required because the document received by the carrier from claimant does not clearly request formal written acceptance of a new or omitted medical condition. If yes, submit a copy of “Notice of Incomplete Claim Response to ‘Post-Agravation Rights’ New Medical Condition or Omitted Medical Condition Claim.” See OAR 438-012-0024(1)(d), (2)(d); OAR 438-012-0085. Stop here.</p>
<input type="checkbox"/>	<input type="checkbox"/>	<p>D-22: RECOMMENDATION: Reopen “Post-Agravation Rights” New/Omitted Medical Condition Claim related to Pre-1966 Injury. (Indicate “yes” if the carrier recommends reopening the pre-1966 “post-aggravation rights” new/omitted medical condition claim). (Indicate “no” if the carrier recommends against reopening the claim).</p>

Dear Claimant,

The carrier contends that you have withdrawn from the work force. If that is true, your claim may not qualify for claim reopening and/or the payment of temporary disability benefits. Please read the attached explanation of the carrier's position and supporting documents.

In order to qualify for claim reopening and/or payment of temporary disability benefits, you must prove that you were in the work force at the time of disability as defined under the criteria in *Dawkins v. Pacific Motor Trucking*, 308 Or 254 (1989). Under that criteria, you are deemed to be in the work force if you meet any **one** of the following three criteria:

I. You were engaged in employment. To meet this requirement, please send us copies of: 1) your tax records; 2) wage-withholding statements; 3) paycheck stubs; and/or 4) a letter from your employer verifying current employment. If you were self-employed or casually employed, please submit copies of bills and receipts relating to your business, or any documents which prove you were working during the relevant time period.

II. Although not employed, you were willing to work and making reasonable efforts to obtain employment. To meet this requirement, please send us a sworn affidavit that you were willing to seek work and were seeking work, and a list of employers you contacted while looking for work, including names, addresses, phone numbers, and dates of contact. If you were receiving unemployment benefits, please send verification of these benefits.

III. You were willing to work, but were not looking for work, because your compensable injury made it futile for you to obtain and perform any type of work for which you are qualified by age, education, and work experience. To meet this requirement, please send us a sworn affidavit that you were willing to work and would have sought work but for your compensable condition, and a medical opinion supporting this position, in other words a doctor's opinion explaining why your compensable injury makes it futile for you to obtain or perform work for which you are qualified.

You must submit this information within 14 days of your receipt of this form or the Board may deny reopening of your claim. Please submit this information to: Own Motion Unit, Workers' Compensation Board, 2601 25th St. SE Ste. 150, Salem OR 97302-1282.

Include a cover letter with the claim number and date of injury listed in items A-10 and A-11 of the carrier's recommendation form. You must mail the carrier a copy of any information you submit to the Board. The copy should be sent to the carrier at the address listed at item A-3 of the carrier's recommendation form. If you need further assistance in this matter, please contact the Own Motion Coordinator at (503) 378-3308 or 1-877-311-8061 (within the State of Oregon).