

DEPARTMENT OF CONSUMER AND BUSINESS SERVICES
WORKERS' COMPENSATION DIVISION
CLAIMS EVALUATION, DETERMINATION AND RECONSIDERATION

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[Bracketed 8 point text is deleted]; **bold/underlined text is added**

EFFECTIVE JANUARY 15, 1998

**OREGON ADMINISTRATIVE RULES
CHAPTER 436, DIVISION 030**

NOTE: Only adopted, amended, and repealed rules are included in this document:

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436-030-0003 Applicability of Rules

(1) Except as provided in section (4) of this rule, these rules apply to all accepted claims for workers' compensation benefits and all requests for reconsideration received by the department on or after the effective date of these rules.

(2) All orders issued by the division to carry out the statute and these rules are considered

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an order of the director.

(3) These rules take the place of the rules adopted on [November 18, 1994] **February 14, 1996**, by Workers' Compensation Division Administrative Order [94-059] **96-052**, and carry out the provisions of ORS 656.726(3), 656.206, 656.214, 656.268, 656.277, 656.325, 656.262, and Section 66 of Chapter 332.

(4) The provisions of OAR 436-030-0009, 030-0020, 030-0030, 030-0115, 030-0125, 030-0135, 030-0145, 030-0155, 030-0165, 030-0175 and 030-0185 apply to all determinations or claims for workers who become medically stationary after July 1, 1990; for claims in which the [claimant] **worker** becomes medically stationary prior to July 2, 1990 the provisions of OAR 436-030-0020, 030-0030, 030-0050 as contained in WCD Administrative Order 13-1987 shall apply.

Stat. Auth.: ORS 656.268, ORS 656.726 and 1995 OR Laws Chapter 332

Stats. Implemented: ORS 656.206, ORS 656.210, ORS 656.212, ORS 656.262, ORS 656.268, ORS 656.277, ORS 656.325, ORS 656.726 and 1995 OR Laws Chapter 332

Hist: Filed 6/30/78 as WCD Admin. Order 8-1978, eff. 7/10/78.
 Amended 3/20/80 as WCD Admin. Order 4-1980, eff. 4/1/80.
 Renumbered from OAR 436-65-030, May 1985.
 Amended 12/17/87 as WCD Admin. Order 13-1987, eff. 1/1/88.
 Amended 6/18/90 as WCD Admin. Order 7-1990, eff. 7/1/90, (temp.).
 Amended 12/10/90 as WCD Admin. Order 33-1990, eff. 12/26/90.
 Amended 8/20/91 as WCD Admin. Order 6-1991, eff. 9/01/91 (temp.).
 Amended 1/17/92 as WCD Admin. Order 5-1992, eff. 2/20/92.
 Amended 1/18/94 as WCD Admin. Order 94-059, eff. 1/1/95.
 Amended 2/14/96 as WCD Admin. Order 96-052, eff. 2/17/96.
Amended 12/22/97 as WCD Admin. Order 97-065, eff. 1/15/98.

436-030-0005 Definitions

Except where the context requires otherwise, the construction of these rules is governed by the definitions given in the Workers' Compensation Law and as follows:

(1) "Administrator" means the Administrator of the Workers' Compensation Division, Department of Consumer and Business Services.

(2) ["Department" means the Department of Consumer and Business Services.

(3) "Determination" means the review by the department or an insurer which establishes the extent of temporary and/or permanent disability to which a worker is entitled as a result of an accepted disabling injury.

[(4) "Director" means the director of the Department of Consumer and Business Services or the director's delegate for the matter.]

[(5) **(3)** "Division" means the Workers' Compensation Division of the Department of Consumer and Business Services.

[(6) **(4)** "Insurer" means the State Accident Insurance Fund, or an insurer authorized under ORS chapter 731 to transact workers' compensation insurance in Oregon, a self-insured employer or a self-insured employer group.

(5) "Mailed or Mailing Date," for the purposes of determining timeliness pursuant to these rules, means the date a document is postmarked. Requests submitted by electronic transmission (by facsimile or "fax") shall be considered mailed as of the date printed on the banner automatically produced by the transmitting fax machine. Hand-delivered

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requests shall be considered mailed as of the date stamped or punched in by the Workers' Compensation Division.

[(7)] **(6)** "Notice of Closure" means a notice to the worker issued by the insurer to close an accepted disabling claim provided by ORS 656.268(4).

[(8)] **(7)** "Reconsideration" means the review of a claim determination by an insurer Notice of Closure or a Determination Order by the department.

[(9)] **(8)** "Statutory closure date" means the date the claim can be closed pursuant to ORS 656.268(1)(a) and (b).

[(10)] **(9)** "Statutory appeal period" means the time frame for appealing a Notice of Closure, Determination Order or Order on Reconsideration.

(a) For closures where the worker is medically stationary prior to June 7, 1995, the appeal period is 180 days from the mailing date of the order.

(b) For closures where the worker is medically stationary on or after June 7, 1995, the appeal period is 60 days from the mailing date of the order. The appeal period for an Order on Reconsideration is 30 days from the mailing date of the order.

(c) ORS 656.268(1)(a) and (b) became effective June 7, 1995. For workers whose claims are closed pursuant to that statute, the medically stationary date will be at some point in the future after June 7, 1995. Therefore, the appeal period for claims closed pursuant to ORS 656.268(1)(a) or (b) is 60 days from the mailing date of the order.

[(11)] **(10)** "Worksheet" means a summary of facts used to derive the awards stated in the Notice of Closure or Determination Order.

Stat. Auth.: ORS 656.268, ORS 656.726 and 1995 OR Laws Chapter 332

Stats. Implemented: ORS 656.005, ORS 656.268, ORS 656.726 and 1995 OR Laws Chapter 332

Hist: Filed 6/30/78 as WCD Admin. Order 8-1978, eff. 7/10/78.
Amended 3/20/80 as WCD Admin. Order 4-1980, eff. 4/1/80
Amended 12/30/81 as WCD Admin. Order 5-1981, eff. 1/1/82.
Renumbered from OAR 436-65-004, May 1985.
Amended 12/17/87 as WCD Admin. Order 13-1987, eff. 1/1/88.
Amended 6/18/90 as WCD Admin. Order 7-1990, eff. 7/1/90, (temp.).
Amended 12/10/90 as WCD Admin. Order 33-1990, eff. 12/26/90.
Amended 11/18/94 as WCD Admin. Order 94-059, eff. 1/1/95.
Amended 2/14/96 as WCD Admin. Order 96-052, eff. 2/17/96.
Amended 12/22/97 as WCD Admin. Order 97-065, eff. 1/15/98.

436-030-0007 Administrative Review

(1) Dispute Resolution Before the director:

(a) Determination Orders issued by the department and Notices of Closure issued by insurers are appealed to the director in accordance with the reconsideration procedures described in OAR 436-030-0115 through OAR 436-030-0185.

(b) Abating, withdrawing or amending an Order on Reconsideration: If a hearing has not been requested **and the statutory time frames for completing the reconsideration proceeding have not expired**, at the director's discretion, the department may abate, withdraw and/or amend an Order on Reconsideration. [within the time limit permitted to appeal a Notice of Closure or Determination Order.] **At the**

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director's discretion, the department may amend the Order on Reconsideration until a hearing is requested or the Order is final by operation of law.

(2) Contested cases before the Hearings Division of the Workers' Compensation Board:

(a) Except as noted in section (3) of this rule, Orders on Reconsideration are appealable to the Hearings Division of the Workers' Compensation Board as follows:

(A) The party must send the request for hearing in writing to the Hearings Division in accordance with ORS 656.283 and the rules of procedure adopted by the Workers' Compensation Board.

(B) Pursuant to OAR 436-030-0145(2) for claims medically stationary on or after June 7, 1995, for the purpose of filing such appeal, the time shall be 30 days from the mailing date of the Order on Reconsideration.

[(B)] **(C)** [The request must be filed within the statutory appeal period for the Notice of Closure or Determination Order.] Pursuant to O[RS]AR 436-030-0145(1) **for claims medically stationary before June 7, 1995,** for the purpose of filing such appeal, the time required to complete the reconsideration proceeding shall not be included in the time limit. **The request for hearing must be filed within the statutory appeal period for the Notice of Closure or Determination Order.**

(b) A party may request a hearing before the Hearings Division of the Workers' Compensation Board on any other action taken pursuant to these rules where a worker's right to compensation or the amount thereof is directly an issue in accordance with the provisions of ORS Chapter 656.

(3) Contested cases before the Workers' Compensation Division's Administrative Law Judge: Pursuant to 183.310 through 183.550 as modified by ORS 183.315 (1) and ORS 656.704(2), any party that disagrees with an action or order of the director pursuant to these rules may request a contested case review, if the matter qualifies for review before the director as a contested case. This may include orders denying reconsideration, jurisdictional dismissals, and other actions or orders of the director pursuant to ORS Chapter 656 which do not involve the payment of compensation, when the matter qualifies for review as a contested case. Orders and actions which qualify for review as contested cases before the director are those specified by statute, by rule or by specific notice of right to such appeal. A party may appeal to the director as follows:

(a) The party must send the request for hearing in writing to the administrator of the Workers' Compensation Division. The request must specify the grounds upon which the denial of reconsideration, or other order or action of the director, is contested.

(b) The appeal must be made within 30 days of the mailing date of the order or notice of action being appealed, unless the director determines that there was good cause for delay and the Administrative Law Judge determines that substantial injustice may otherwise result.

(c) The Workers' Compensation Division will conduct the hearing in accordance with the rules governing contested case hearings in OAR 436-001.

[(d) Any order that results from a contested case is a preliminary order subject to revision by the director pursuant to OAR 436-001-

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0270.]

(4) Contested Case Hearings of Sanctions and Civil Penalties: Under ORS 656.704, any party aggrieved by a proposed order or proposed assessment of a civil penalty issued by the director pursuant to ORS 656.254, 656.735, 656.745 or 656.750 may request a hearing by the Hearings Division as follows:

(a) A written request for hearing must be sent to the administrator of the Workers' Compensation Division. The request must specify the grounds upon which the proposed order or assessment is contested.

(b) The request must be [received by] **mailed to** the Workers' Compensation Division within 20 calendar days after service of the order or notice of assessment.

(c) The Workers' Compensation Division shall forward the request and other pertinent information to the Hearings Division of the Workers' Compensation Board.

(d) An Administrative Law Judge from the Hearings Division, acting on behalf of the director, shall conduct the hearing in accordance with ORS 656.740 and ORS Chapter 183.

(5) Director's Administrative Review of other actions: Except as covered under sections (1) through (4) of this rule, any party seeking an action or decision by the director or aggrieved by an action taken by any other party pursuant to these rules, may request administrative review by the director as follows:

(a) A written request must be sent to the administrator within ninety (90) days of the disputed action and must specify the grounds upon which the action is taken, unless the director determines that there was good cause for delay or that substantial injustice may result otherwise.

(b) The Workers' Compensation Division may require and allow such evidence as it deems appropriate to complete the review.

(c) A director's order will be issued and will specify if the order is final or if it may be appealed in accordance with section (3) of this rule.

Stat. Auth.: ORS 656.268, ORS 656.726 and 1995 OR Laws Chapter 332
Stats. Implemented: ORS 656.268, ORS 656.726 and 1995 OR Laws Chapter 332
Hist: Filed 06/30/78 as WCD Admin. Order 8-1978, eff. 07/10/78.
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 Amended 6/18/90 as WCD Admin. Order 7-1990, eff. 7/1/90, (temp.).
 Renumbered from OAR 436-030-0020.
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 Amended 1/17/92 as WCD Admin. Order 5-1992, eff. 2/20/92.
 Amended 11/18/94 as WCD Admin. Order 94-059, eff. 1/1/95.
 Amended 2/14/96 as WCD Admin. Order 96-052, eff. 2/17/96.
Amended 12/22/97 as WCD Admin. Order 97-065, eff. 1/15/98.

436-030-0010 Department Responsibility

(1) The department, when requested by a party to a claim, is responsible for, but not limited to:

(a) determining the extent of permanent partial disability;

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- (b) determining temporary disability benefits;
- (c) determining permanent total disability;
- (d) determining medically stationary, nonstationary and statutory closure dates;
- (e) reviewing and determining the disabling/nondisabling status of a claim;
- (f) reviewing permanent total disability awards;
- (g) reviewing permanent unscheduled disability awards pursuant to ORS 656.325(3);
- (h) granting/approving offsets of overpayments pursuant to ORS 656.268(13);
- (i) conducting the mandatory reconsideration proceeding when a party is dissatisfied with a Notice of Closure or Determination Order, and assessing penalties and attorney fees where appropriate; **and**

(j) closing all claims pursuant to ORS 656.307.

(2) Applicable to these rules, the director may, unless otherwise obligated by statute, in the director's discretion waive any procedural rules as justice so requires.

Stat. Auth.: ORS 656.268, ORS 656.726 and 1995 OR Laws Chapter 332
Stats. Implemented: ORS 656.206, ORS 656.210, ORS 656.212, ORS 656.214, ORS 656.268, ORS 656.277, ORS 656.325, ORS 656.726 and 1995 OR Laws Chapter 332
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 Amended 6/30/78 as WCD Admin. Order 8-1978, eff. 7/10/78.
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 Amended 12/30/81 as WCD Admin. Order 5-1981, eff. 1/1/82.
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 Amended 12/17/87 as WCD Admin. Order 13-1987, eff. 1/1/88.
 Amended 6/18/90 as WCD Admin. Order 7-1990, eff. 7/1/90, (temp.).
 Amended 12/10/90 as WCD Admin. Order 33-1990, eff. 12/26/90.
 Amended 11/18/94 as WCD Admin. Order 94-059, eff. 1/1/95.
 Amended 2/14/96 as WCD Admin. Order 96-052, eff. 2/17/96.
Amended 12/22/97 as WCD Admin. Order 97-065, eff. 1/15/98.

436-030-0015 Insurer Responsibility

(1) When an insurer elects to issue a Notice of Closure, the insurer is responsible for:

(a) Providing **the department and parties pursuant to OAR 436-030-0020** a copy of the Notice of Closure, a copy of the worksheet upon which the Notice is based, [and] a completed "Insurer Notice of Closure Summary or Request for Determination" (department form 1503), [to the department and parties pursuant to OAR 436-030-0020] **and an updated notice of acceptance at closure that specifies which conditions are compensable, as prescribed in section (2) of this rule;**

(b) Providing the department, the worker or the worker's representative, if requested, the records used to issue the Notice of Closure; and

(c) Maintaining a copy of the worksheet upon which the Notice of Closure is based in its claim file for audit purposes.

(2) When an insurer elects to request claim determination by the department, the insurer is responsible for providing:

(a) A completed "Insurer Notice of Closure Summary or Request for Determination[.]"

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(department form 1503);

(b) Copies of all medical and vocational reports and other evidence applicable to the claim;

(c) A closing medical examination report which describes in detail all permanent residuals attributable to the accepted [claim] **condition(s)** pursuant to OAR 436-010-[0080]**0280** and OAR 436-035;

(d) The dates of medically verified time loss including dates of modified work. Any reasons for broken periods of time loss shall also be explained or documented;

(e) The name and address of the worker's attorney, if represented;

(f) The name and address of the worker's attending physician; and

(g) The [accepted and denied conditions of the claim.] **updated notice of acceptance at closure;**

(A) The updated notice of acceptance at closure shall be provided timely. For purposes of this rule, a timely updated notice of acceptance at closure shall be issued no sooner than the date the claim qualified for closure, or 30 days prior to claim closure (whichever occurs closer to actual closure), but not later than the mailing date of the closure or the request for department closure.

(B) The updated notice of acceptance at closure shall contain the following information and language:

(i) all compensable conditions that have been accepted, even if the accepted condition was ordered by litigation and is under appeal;

(ii) language - NOTICE TO WORKER: THIS NOTICE IS IN LIEU OF ALL PRIOR ACCEPTANCES AND INCLUDES ALL CONDITIONS ACCEPTED ON PRIOR NOTICES OF ACCEPTANCE, UNLESS DENIED. THESE ARE THE ONLY CONDITIONS CONSIDERED AT THE TIME OF CLAIM CLOSURE. IF YOU BELIEVE A CONDITION HAS BEEN INCORRECTLY OMITTED FROM THIS NOTICE, OR THIS NOTICE IS OTHERWISE DEFICIENT, YOU MUST COMMUNICATE THE SPECIFIC OBJECTION TO THE INSURER IN WRITING;

(iii) in the event an omission or error requires a corrected updated notice of acceptance at closure, the word "CORRECTED" shall appear in capital letters adjacent to the word "updated";

(iv) in the event that the "initial notice of acceptance" is the same as the "updated notice of acceptance at closure," both titles shall appear near the top of the document;

(3) Copies of Notices of Refusal to Close pursuant to OAR 436-030-0017, shall be mailed to the department and the parties.

(4) In claims involving unscheduled injuries to, or disease of, body parts or conditions pursuant to OAR 436-035-0330 through 436-035-0450, the insurer shall provide the worker's work history and education to include:

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(a) The worker's level of education; **and**

(b) The worker's work history pursuant to OAR **436-030-0300 and** 436-035-0310 including the job at injury and work history for five years preceding the determination request. The work history shall include the Dictionary of Occupational Titles (DOT) code with the Specific Vocational Preparation (SVP) for the five years preceding determination, including dates or period of time spent at each position.]; and

(c) Documentation of any periods of time the worker was incarcerated.]

(5) The insurer shall provide any other records or information pertinent to claim determination that the department may require within appropriate period.

(6) The insurer shall notify the worker and the worker's representative pursuant to ORS 656.331(1)(b), when a request for determination is made and provide the worker's attorney and the employer, if requested, the same documents required for claim closure.

(7) The insurer shall not issue a Notice of Closure if an insurer's Determination Request (Form 1503) has been sent to the department within the past 70 days and the matter is still pending resolution, except for the following:

(a) A 1503 may be rescinded after the insurer's receipt of written confirmation from the department that it has accepted the request to rescind the 1503. The insurer may request the 1503 be rescinded in writing or by telephone.

(b) The insurer or self-insured employer may proceed to issue a Notice of Closure after rescinding the 1503 request in accordance with subsection (a) of this section.

(c) Notices of Closure issued by the insurer in violation of this rule are void and without legal effect.

(8) The insurer shall not issue a Notice of Closure on an accepted nondisabling claim. Notices of Closure[s] issued by the insurer in violation of this rule are void and without legal effect. Medically stationary status in nondisabling claims may be documented by the attending physician's statement of medically stationary status.

(9) Failure to meet the requirements and timeframes of this rule [shall] **may** result in civil penalties pursuant to OAR 436-030-0580.

(10) **Except as provided for in OAR 436-030-0135(8)**, [w]hen a condition is accepted after a closure, i.e. per Opinion and Order, etc., the insurer [may] **shall, pursuant to these rules:**

(a) issue a Notice of Closure, considering only the newly accepted condition; [or] **OR**

(b) request the department to make a determination, considering only the newly accepted condition[, pursuant to these rules].

(11) Denials issued pursuant to ORS 656.262(7)(b), must clearly identify the phrase "major contributing cause" in the text of the denial.

Stat. Auth.: ORS 656.268, ORS 656.726 and 1995 OR Laws Chapter 332

Stats. Implemented: ORS 656.268, ORS 656.331, ORS 656.726 and 1995 OR Laws Chapter 332

Hist: Amended and Renumbered 11/18/94 from 436-030-0020 and 030 as WCD Admin. Order 94-059, eff. 1/1/95.
Amended 2/14/96 as WCD Admin. Order 96-052, eff. 2/17/96.

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Amended 12/22/97 as WCD Admin. Order 97-065, eff. 1/15/98.

436-030-0017 Requests for Claim Closure by the Worker

(1) A worker who has returned to work may request closure from the insurer. The insurer shall, within [14] **10** days of receipt of [said] a written request, respond pursuant to ORS 656.268(4)(d).[.]

[(a) request a Determination Order by the department; or

(b) issue a Notice of Closure; or

(c) issue a Notice of Refusal to Close advising the worker of the appeal rights in accordance with ORS 656.268(4)(d).]

(2) If an insurer issues a notice of refusal to close the claim, the notice shall be identified in capital letters as a "NOTICE OF REFUSAL TO CLOSE" and shall include the following information_ and appeal language:

(a) name of the worker;

(b) date of injury;

(c) [worker's social security number

(d)] insurer's claim number;

(e)] **(d)** mailing date of the notice;

(f)] **(e)** the accepted and denied conditions;

(g)] **(f)** "IF YOU DISAGREE WITH THIS NOTICE OF REFUSAL TO CLOSE YOUR CLAIM, YOU MUST FILE A LETTER OF DISAGREEMENT WITH THE WORKERS' COMPENSATION BOARD WITHIN 60 DAYS FROM THE DATE OF THIS NOTICE. YOUR LETTER MUST STATE THAT YOU WANT A HEARING, NOTE YOUR ADDRESS AND THE DATE OF YOUR ACCIDENT, IF YOU KNOW THE DATE. YOU MUST MAIL YOUR LETTER OF DISAGREEMENT TO THE WORKERS' COMPENSATION BOARD, 2250 MCGILCHRIST STREET SE, SALEM, OR 97310. IF YOUR CLAIM QUALIFIES AND YOU REQUEST SUCH, YOU MAY RECEIVE AN EXPEDITED HEARING (WITHIN 30 DAYS). YOUR REQUEST CANNOT, BY LAW, AFFECT YOUR EMPLOYMENT. IF YOU DO NOT FILE YOUR LETTER OF DISAGREEMENT WITHIN 60 DAYS FROM THE DATE OF THIS NOTICE, YOUR HEARING MAY BE DENIED AS THE APPEAL TIME **HAS** PASSED. YOU MAY BE REPRESENTED BY AN ATTORNEY IF YOU SO CHOOSE."

(3) If the worker disagrees with the Notice of Refusal to Close, the worker may request a hearing from the Workers' Compensation Board.

(4) Failure by the insurer to meet the requirements of section (1) of this rule [shall] **may** result in civil penalties against the insurer pursuant to OAR 436-030-0580.

Stat. Auth.: ORS 656.268, ORS 656.726 and 1995 OR Laws Chapter 332

Stats. Implemented: ORS 656.268, ORS 656.319, ORS 656.726, ORS 656.745 and 1995 OR Laws Chapter 332

Hist: Amended 11/18/94 as WCD Admin. Order 94-059, eff. 1/1/95.
Amended 2/14/96 as WCD Admin. Order 96-052, eff. 2/17/96.

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Amended 12/22/97 as WCDAdmin. Order 97-065, eff. 1/15/98.

436-030-0020 Requirements for Claim Closure by Insurers

(1) The insurer may issue a Notice of Closure on an accepted disabling claim when medical information indicates the worker is medically stationary prior to June 7, 1995, and the worker has:

- (a) returned to regular or modified work; or
- (b) been released to return to regular or modified work by the attending physician; or
- (c) ceased to be enrolled and actively engaged in a department authorized training program and has returned to work.

(2) The insurer may issue a Notice of Closure on an accepted disabling claim when medical information indicates the worker is medically stationary on or after June 7, 1995, and the worker has:

- (a) returned or been released to regular or modified work; or
- (b) the worker's compensable condition is no longer the major contributing cause of the worker's combined or consequential condition.

(3) The insurer may issue a Notice of Closure on an accepted disabling claim when medical information indicates the worker's condition is not medically stationary and:

- (a) The accepted injury/condition is no longer the major contributing cause of the worker's combined or consequential condition(s), a major contributing cause denial has been issued and the worker is not enrolled and actively engaged in training; or
- (b) The worker fails to seek medical treatment for 30 days for reasons within the worker's control and the worker has been notified of pending actions in accordance with these rules; or
- (c) The worker fails to attend a mandatory closing examination for reasons within the worker's control and the worker has been notified of pending action(s) in accordance with these rules.

(4) In accordance with OAR 436-030-0034 or 0035, when the insurer closes the claim, it shall issue a Notice of Closure to the worker within 14 days after:

(a) Evidence is received from the attending physician which shows the worker's condition is medically stationary, and information is sufficient to determine the extent of any disability, or

(b) Evidence is received which shows the claim is ready for closure pursuant to ORS 656.268(1) and information is sufficient to determine the extent of any disability.

(5) When making a determination of disability, the insurer shall:

- (a) apply OAR 436-030-0034 regarding non-medically stationary status;
- (b) apply OAR 436-030-0035 regarding medically stationary status;
- (c) apply OAR 436-030-0036 regarding temporary disability determination;

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- (d) apply OAR 436-030-0038 regarding determining permanent partial disability; and
- (e) prepare a summary worksheet which contains all the information, and is in the form and format, prescribed by bulletin of the director.
- (6) For the purposes of section (3) of this rule, medical information is sufficient if it includes the information required in OAR 436-030-0015(2)(3)(4) and OAR 436-010-[0080]0280 and the Disability Rating Standards, OAR 436-035.
- (7) If the worker's condition became stationary on or after January 1, 1988, the insurer may determine the extent of permanent disability. The insurer shall apply the standards developed for the rating of permanent disability pursuant to ORS 656.726(3).
- (8) The Notice of Closure shall be effective the date mailed. The notice shall be in the form and format that the director shall describe by bulletin. The notice shall include but not be limited to:
- (a) the appropriate dollar value of any permanent disability based on the statutory value for the degree;
 - (b) the body part(s) awarded disability, coded to the table of body part codes, the percentage of loss, and the number of degrees that loss represents;
 - (c) duration of temporary **total and temporary partial** disability compensation;
 - (d) the medically stationary date or date the claim statutorily qualifies for closure pursuant to ORS 656.268(1) and these rules;
 - (e) the worker's aggravation rights;
 - (f) the worker's appeal rights;
 - (g) the right of the worker to consult with the Ombudsman for injured workers; and
 - (h) the worker's return to work status.
- (9) The original and three color coded copies of the Notice of Closure shall be mailed to:
- (a) the worker (white copy);
 - (b) the employer (goldenrod copy);
 - (c) the department (yellow copy);
 - (d) the worker's attorney, if represented.
- (10) Where prior approval has been given by the department, an insurer may use electronically produced Notice of Closure forms where the computerized format is consistent with the department determination order format. The original and three copies of the electronically produced form shall be mailed to all affected parties pursuant to section (9) of this rule.
- (11) An insurer who [intentionally or repeatedly] fails to provide the worker's attorney a copy of the Notice of Closure may be assessed a civil penalty pursuant to OAR 436-030-0580. [For the purposes of this rule, "repeatedly fails" refers to any instance where the attorney has requested a copy of the Notice of Closure on a particular

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claim and must subsequently make a second request due to the insurer's failure to provide the requested copy.]

(12) These rules do not prohibit an insurer from rescinding or correcting its Notice of Closure or Notice of Refusal to Close prior to the expiration of the appeal period and prior to receipt of a request for reconsideration of the Notice of Closure by the department. A Notice of Closure may be corrected or rescinded when:

(a) it is found to contain an inadvertent error, omission, or a typographical or clerical error which includes discrepancies between the worksheet and Notice of Closure;

(b) the insurer has been instructed to correct or rescind a Notice of Closure in the course of a department audit of insurer claim files;

(c) additional information has been received pertaining to the worker at or prior to the Notice of Closure, including but not limited to, [wages or unemployment benefits previously paid the worker, actual time worked,] periods of time loss, medically stationary status or permanent disability at the time the Notice was issued; or

(d) the department has instructed the insurer to correct a Notice of Closure because it did not contain information pursuant to section [(7)] **(8)** of this rule.

(13) Requests for reconsideration of a Notice of Closure corrected pursuant to section (12) of this rule must be received within the statutory appeal period for the corrected Notice of Closure. Requests for reconsideration of a corrected Notice of Closure may only address those areas changed by the corrected Notice.

(14) Insurers may allow adjustments of benefits awarded to the worker pursuant to the documentation requirements of OAR 436-060-0170 for the following purposes:

(a) To recover payments for permanent disability which were made prematurely;

(b) To recover overpayments for temporary disability;

(c) To recover overpayments for other than temporary disability such as prepaid travel expenses where travel was not completed, prescription reimbursements or other benefits payable under ORS 656.001 to 656.794.

(15) The insurer may allow overpayments made on a claim with the same insurer to be deducted from compensation to which the worker is entitled but has not yet been paid.

(16) [When a condition is accepted after a closure, i.e. per Opinion and Order, etc., the insurer may issue a Notice of Closure, considering only the newly accepted condition, pursuant to these rules]

(17) If after claim closure, when a worker is medically stationary prior to June 7, 1995, and the worker becomes enrolled and actively engaged in a department approved training program pursuant to OAR 436-0120:

(a) Permanent disability shall be redetermined pursuant to ORS 656.268 when the worker has ended training and the worker's condition is medically stationary or the claim otherwise qualifies for closure in accordance with these rules. If the worker has remained medically stationary throughout training and the closing examination is six months or older, a current medical examination will be required for redetermination unless the worker's attending physician

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provides a written statement that there has been no change in the worker's condition since the previous closing examination.

(b) The insurer shall submit the claim to the department for determination if the worker has not returned to work or the insurer chooses not to close the claim pursuant to OAR 436-030-0020(1).

[(18)] **(17)** If after claim closure, when a worker is medically stationary on or after June 7, 1995, and the worker becomes enrolled and actively engaged in a department approved training program pursuant to OAR 436-0120:

(a) Unscheduled permanent disability shall be redetermined pursuant to ORS 656.268 when the worker has ended training and the worker's condition is medically stationary or the claim otherwise qualifies for closure in accordance with these rules. If the worker has remained medically stationary throughout training and the closing examination is six months or older, a current medical examination will be required for redetermination unless the worker's attending physician provides a written statement that there has been no change in the worker's condition since the previous closing examination.

(b) No redetermination of permanent disability shall be made for scheduled claims or portions of claims. The scheduled permanent disability shall remain unchanged from the last award of compensation in that claim.

(c) The insurer shall submit the claim to the department for determination if the worker has not returned to work or has not been released to work.

Stat. Auth.: ORS 656.268, ORS 656.726 and 1995 OR Laws Chapter 332
Stats. Implemented: ORS 656.210, ORS 656.212, ORS 656.214, ORS 656.268, ORS 656.270, ORS 656.726, ORS 656.745 and 1995 OR Laws Chapter 332
Hist: Amended 3/20/80 as WCD Admin. Order 4-1980, eff. 4/1/80.
 Amended 12/30/81 as WCD Admin. Order 5-1981, eff. 1/1/82.
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 Amended 12/10/90 as WCD Admin. Order 33-1990, eff. 12/26/90.
 Amended 1/17/92 as WCD Admin. Order 5-1992, eff. 2/20/92.
 Amended 11/18/94 as WCD Admin. Order 94-059, eff. 1/1/95.
 Amended 2/14/96 as WCD Admin. Order 96-052, eff. 2/17/96.
Amended 12/22/97 as WCD Admin. Order 97-065, eff. 1/15/98.

436-030-0030 Requirements for Claim Closure By the Department:

(1) Requests by the insurer for determination by the department shall be as prescribed by the director.

(2) Unless the worker is actively engaged in training, the insurer shall request determination for those claims it elects not to close within 14 days after the worker becomes medically stationary and sufficient information is available to determine the extent of disability pursuant to sections 030-0015(2) and [(3)] **(4)** of these rules. [For purposes of this rule, a determination order shall be deemed to have been requested on the date the Form 1503 is received by the department.]

(3) The insurer shall notify the worker and the worker's representative pursuant to ORS 656.331(1)(b)[.] when a request for determination is made. [As defined in OAR 436-060-0200(2), intentional or repeated f]Failure to notify the worker or the worker's representative pursuant to this section may

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result in civil penalties pursuant to OAR 436-030-0580.

(4) The department shall issue a Determination Order within 10 working days if claim closure is premature or inappropriate because:

- (a) The worker is not medically stationary;
- (b) The worker is enrolled and actively engaged in a department approved training program; and/or
- (c) The claim does not [statutorily] qualify for closure pursuant to ORS 656.268(1) and these rules.

(5) When requested by the insurer, the department shall declare the date on which the worker became medically stationary if the worker was in training pursuant to OAR 436-0120, and the worker's date of injury was after December 31, 1973 and before January 1, 1986. This date will control administrative fund reimbursements to insurers by the department for injuries prior to January 1, 1986.

(6) **For purposes of this section, a determination order shall be deemed to have been requested on the date the Form 1503 is received by the department.** Upon receipt of a request by the insurer for determination the department shall:

- (a) apply standards developed pursuant to ORS 656.726(3) when evaluating the permanent disability of an injured worker; and
- (b) issue a Determination Order within 10 working days following receipt of the request for determination; or
- (c) postpone the determination for not more than an additional 60 days to obtain additional information necessary for that determination and notify the worker and any representative of the worker within 10 working days following receipt of the request.

(7) Where determination has been postponed to obtain additional information and the insurer fails to respond to the department request for that information by the date requested, penalties may be assessed pursuant to OAR 436-030-0580. In cases where the insurer provides sufficient documentation to substantiate lack of cooperation by the medical provider, the provider will be sent a warning letter about possible penalties and a date for submitting the requested information. Failure by the medical provider to submit the requested information within the specified period may result in the subsequent issuance of civil penalties, pursuant to OAR 436-030-0580.

(8) Pursuant to section (7) of this rule, adequate documentation to substantiate lack of cooperation by the medical provider would include:

- (a) copies of letters to the medical provider;
- (b) memos to the claim file of follow-up phone calls and/or the lack of response;
- (c) letters from the medical provider indicating a lack of cooperation; or
- (d) medical reports received by the insurer after adequate instruction by the insurer or

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department which do not supply the requested information or which supply information that is not consistent with the Disability Rating Standards in OAR 436-035.

(9) The effective date of the Determination Order shall be the date it is mailed. The mailing date appears on the order under "Date of Determination".

(10) A Determination Order will be mailed to the insurer. Copies of the Determination Order will be mailed to the worker at the worker's last known address, the worker's representative, and the employer at injury.

(11) The department may allow overpayments made by the same insurer to be deducted from compensation to which the worker is entitled but has not yet been paid.

(12) The department may allow adjustments of benefits awarded to the worker for the following purposes:

(a) To recover payments for permanent disability which were made prematurely;

(b) To recover overpayments for temporary disability; or

(c) To recover overpayments for other than temporary disability such as prepaid travel expenses where travel was not completed, prescription reimbursements or other benefits payable under ORS 656.001 to 656.794.

(13) The department may change or cancel any order it issues if it has made an inadvertent error or omission which affects the order only if request for reconsideration pursuant to these rules has not been made and the appeal rights have not expired. Determination Orders may be corrected or rescinded when:

(a) the Determination Order contains a typographical or clerical error which includes discrepancies between the worksheet and the order;

(b) additional information has been received pertaining to the worker at or prior to the Determination Order including, but not limited to, [wages or unemployment benefits previously paid the worker, actual time worked,] periods of time loss, or medically stationary status at the time the Order was issued;

(c) additional information has been received pertaining to the permanent disability that pertains to the worker's condition prior to closure or was generated before the closure.

(14) Requests for reconsideration of a Determination Order corrected pursuant to section (13) of this rule must be ^[received] **mailed** within the statutory **appeal** period. Requests for reconsideration of a corrected Determination Order may only address those areas changed by the corrected Order.

(15) If, after claim closure, when a worker is medically stationary prior to June 7, 1995, and the worker becomes enrolled and actively engaged in a department approved training program pursuant to OAR 436-0120:

(a) Permanent disability shall be redetermined pursuant to ORS 656.268 when the worker has ended training and the worker's accepted compensable condition is medically stationary. If the worker has remained medically stationary throughout training and the closing examination is six months or older, a current medical examination will be required for redetermination unless

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the worker's attending physician provides a written statement that there has been no change in the worker's condition since the previous closing examination.

(b) The insurer shall submit the claim to the department for determination if the worker has not returned to work.

(16) If after claim closure, when a worker is medically stationary on or after June 7, 1995, and the worker becomes enrolled and actively engaged in a department approved training program pursuant to OAR 436-0120:

(a) Unscheduled permanent disability shall be redetermined pursuant to ORS 656.268 when the worker has ended training and the worker's condition is medically stationary or the claim otherwise qualifies for closure in accordance with these rules. If the worker has remained medically stationary throughout training and the closing examination is six months or older, a current medical examination will be required for redetermination unless the worker's attending physician provides a written statement that there has been no change in the worker's condition since the previous closing examination.

(b) No redetermination of permanent disability shall be made for scheduled claims or portions of claims. The scheduled permanent disability shall remain unchanged from the last award of compensation in that claim.

[(17) When a condition is accepted after a closure, i.e., per Opinion and Order, etc., the insurer may request the department to make a determination, considering only the newly accepted condition, pursuant to these rules.]

Stat. Auth.: ORS 656.268, ORS 656.726 and 1995 OR Laws Chapter 332

Stats. Implemented: ORS 656.214, ORS 656.268, ORS 656.331, ORS 656.726, ORS 656.745 and 1995 OR Laws Chapter 332

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 Amended 12/10/90 as WCD Admin. Order 33-1990, eff. 12/26/90.
 Amended 1/17/92 as WCD Admin. Order 5-1992, eff. 2/20/92.
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 Amended 2/14/96 as WCD Admin. Order 96-052, eff. 2/17/96.
Amended 12/22/97 as WCD Admin. Order 97-065, eff. 1/15/98.

436-030-0034 Claim Closure When the Worker is Not Medically Stationary

(1) A claim may be closed by the insurer or Department when the worker is not medically stationary and **when** the worker has not sought medical care for a period in excess of 30 days, without the instruction or approval of the attending physician, for reasons within the worker's control; and

(a) The insurer has notified the worker **after the close of that 30-day period**, by certified letter, that claim closure [will] **may** result for failure to seek medical treatment for a period of 30 days. The notification letter shall inform the worker of the worker's responsibility to seek medical treatment in a timely manner, and shall inform the worker of the consequences for failing to do so, including claim closure.

(b) Workers shall be given 14 days **from the mailing date** to respond to the certified notification letter before any further action is taken by the insurer towards claim closure.

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[c] **(2) When a worker fails to seek treatment for a period in excess of 30 days,**
 [T]the date the claim qualifies for closure [(statutory closure date)] shall be the latest (most chronologically recent) of the following which occurs prior to the closure:

[(A)] **(a) 30 days from the last [qualified physician examination date] treatment provided or authorized by the attending physician;**

[(B)] **(b) the date the attending physician recommended a follow-up visit and the worker failed to attend for reasons within the worker's control;**

[(C)] **(c) the date the worker returns to or is released to regular work if it is after the last examination date;**

[(D)] **(d) the date the insurer receives, prior to the 14th day after the notification letter was mailed, a written response from the worker regarding the certified notification letter and failure to treat.**

[(2)] **(3) A claim may be closed when the worker is not medically stationary, and the worker fails to attend a mandatory closing examination for reasons within the worker's control, and**

(a) The insurer has notified the worker, by certified letter, **at least 10 days** prior to the mandatory examination, that claim closure [will] **may** result for failure to attend a mandatory closing examination. The notification letter shall inform the worker of the worker's responsibility to attend the mandatory closing examination and of the consequences for failing to do so.

(b) Workers [shall be given 14 days to respond to the certified notification letter] **have 7 days from the date of exam to demonstrate good cause for failing to attend,** before any further action is taken by the insurer toward claim closure.

(c) Where the worker fails to attend a mandatory closing examination for reasons within the worker's control, the date the claim qualifies for closure [(statutory closure date)] shall be the date of the failed mandatory closing examination.

(d) Where a closing exam has been scheduled between a worker and attending physician directly, insurers may close pursuant to (1) of this section.

[(3)] **(4) A claim may be closed when the worker is not medically stationary, and a major contributing cause denial has been issued.**

(a) The major contributing cause denial shall inform the worker that claim closure [will] **may** result from the issuance of the denial and other information required by these rules.

(b) When a "major contributing cause" denial has been issued, the date the claim qualifies for closure shall be the date the insurer receives information sufficient to determine the extent of any permanent disability pursuant to OAR 436-035-0007[(4)]**(5)** or the date of the denial, whichever is later.

[(4)] **(5) The attending physician shall be copied on all notification and denial letters applicable to this rule.**

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[(5)] **(6)** When (1), (2) [and] **or** (3) occur concurrently, the earliest **date the claim qualifies for [statutory] closure shall be [date is] used to close the claim and noted on the order or notice.**

[(6)] **(7)** When a suspension order, **pursuant to OAR 436-060-0095 and OAR 436-060-0105,** has been issued by the Department, the date the claim qualifies for closure is the date of the suspension order.

[(7)] **(8)** When a worker fails to seek treatment with **an** [qualified] attending physician pursuant to ORS 656.005(12), the claim may be closed pursuant to sections **(1) and (2)** of this rule. All notices must clearly identify the reason for the closure is because of failure to treat with **an** [qualified] attending physician.

Stat. Auth.: ORS 656.262, ORS 656.268, ORS 656.726 and 1995 OR Laws Chapter 332

Stats. Implemented: ORS 656.268, ORS 656.726 and 1995 OR Laws Chapter 332

Hist: Filed 2/14/96 as WCD Admin. Order 96-052, eff. 2/17/96.

Amended 12/22/97 as WCD Admin. Order 97-065, eff. 1/15/98.

436-030-0035 Determining Medically Stationary Status

(1) A worker's compensable condition shall be determined to be medically stationary when the attending physician or a preponderance of medical opinion declares the worker either "medically stationary," "medically stable," or uses other language meaning the same thing.

(2) When there is a conflict in the medical opinions as to whether or not a worker's compensable condition is medically stationary, more weight shall be given to medical opinions that are based on the most accurate history, on the most objective findings, on sound medical principles, and clear and concise reasoning.

(3) Where there is not a preponderance of medical opinion stating a worker's compensable condition is or is not medically stationary, deference shall generally be given to the opinion of the attending physician. However, in cases where expert analysis is important, deference shall be given to the opinion of the physician with the greatest expertise in, and understanding of, the worker's condition.

(4) When there is a conflict as to the date upon which a worker's compensable condition became medically stationary, the following conditions shall govern the determination of the medically stationary date. The date a worker is medically stationary is the earliest date that a preponderance is established pursuant to section (2) of this rule. The date of the examination, not the date of the report, controls the medically stationary date.

(5) Notwithstanding sections (1) through (4) of this rule, OAR 436-035-0007 requires the attending physician's concurrence or comments when the attending physician arranges, or refers the worker for, a closing examination with another physician to determine the extent of impairment, or when the insurer refers a worker for an insurer medical examination. A concurrence with another physician's report is an agreement in every particular, including the medically stationary impression and date, unless the physician expressly states to the contrary and explains the reasons for disagreement. **Concurrence shall not be presumed in the absence of the attending physician's response.**

(6) A worker is medically stationary on the date of the examination when so specified by

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a physician. When a specific date is not indicated, a worker is presumed medically stationary on the date of the last examination, prior to the date of the medically stationary opinion. Physician projected medically stationary dates cannot be used to establish a medically stationary date.

(7) If the worker is incarcerated or confined in some other manner and unable to freely seek medical treatment, the insurer shall arrange for medical examinations to be completed at the facility where the worker is located or at some other location accessible to the worker.

Stat. Auth.: ORS 656.268, ORS 656.726 and 1995 OR Laws Chapter 332
Stats. Implemented: ORS 656.268, ORS 656.726 and 1995 OR Laws Chapter 332
Hist: Filed 6/18/90 as WCD Admin. Order 7-1990, eff. 7/1/90 (temp.).
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Amended 12/22/97 as WCD Admin. Order 97-065, eff. 1/15/98.

436-030-0036 Determining Temporary Disability

(1) Temporary disability shall be determined pursuant to **ORS Chapter 656**, OAR 436-060 [Chapter 656] and this rule, less time worked. Beginning and ending dates of authorized temporary disability shall be noted on the Determination Order or Notice of Closure, as well as the statements "Less time worked" and "Temporary disability was determined in accordance with the law".

(2) Except as provided for in section (3) of this rule **and ORS 656.268(9)**, a worker is not entitled to any award for temporary disability for any period of time in which the worker is medically stationary.

(3) Awards of temporary disability shall include the day the worker is medically stationary or the [statutory closure] date **the claim otherwise qualifies for closure**, unless temporary disability is not authorized for another reason at that time.

Stat. Auth.: ORS 656.268, ORS 656.726 and 1995 OR Laws Chapter 332
Stats. Implemented: ORS 656.005, ORS 656.160, ORS 656.210, ORS 656.212,
 ORS 656.236, ORS 656.245, ORS 656.262, ORS 656.268,
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Amended 12/22/97 as WCD Admin. Order 97-065, eff. 1/15/98.

436-030-0038 Permanent Partial Disability

The standards developed pursuant to ORS 656.726(3) and contained in OAR 436-035 shall be applied when evaluating a worker's permanent partial disability. The Notice of Closure or department Determination Order shall report the body part, percentage of loss, number of degrees that loss represents and the dollar value for that loss based on the value of the degree [at the time of injury]. Body part codes shall be reported as prescribed by the director.

Stat. Auth.: ORS 656.268, ORS 656.726 and 1995 OR Laws Chapter 332
Stats. Implemented: ORS 656.214, ORS 656.268, ORS 656.726 and 1995 OR Laws Chapter 332
Hist: Filed 11/18/94 as WCD Admin. Order 94-059, eff. 1/1/95.
 Amended 2/14/96 as WCD Admin. Order 96-052, eff. 2/17/96.

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Amended 12/22/97 as WCAdmin. Order 97-065, eff. 1/15/98.

436-030-0045 Disabling/Nondisabling Reporting Requirements and Change in Status Determinations

(1) When an insurer receives notice or knowledge that a nondisabling injury has become disabling, the insurer shall do one of the following:

(a) If the insurer agrees that the claim is or originally was disabling, an "Insurer's Report", Form 440-1502, indicating a change in status shall be submitted to the department within 21 days from the date of receipt of the notice or knowledge. A notice of change of status to disabling shall be sent to the worker, and to the worker's representative, explaining the change in status. If the claim qualifies for closure, the insurer may close the claim in accordance with ORS 656.268(4) and these rules or submit an "Insurer Notice of Closure Summary or Request for Determination", Form 440-1503, requesting department closure; OR

(b) If the insurer disagrees that the claim is or originally was disabling, or is unable to decide whether the claim is disabling, the insurer shall submit an "Insurer's Report", Form 440-1502, and "Insurer Notice of Closure Summary or Request for Determination", Form 1503, to the department with copies of the Form 801 and Notice of Acceptance and all medical, vocational, and time loss records within 21 days from receipt of the notice or knowledge. The 1502 form shall indicate that the claim is nondisabling, and will state in the "explanation" section that the claim is being reported pursuant to ORS 656.277 for department review of the nondisabling classification. A copy of the Form 1503 shall be sent to the worker and the worker's representative, explaining that the worker's assertion that the claim is disabling has been reported to the director for determination.

(2) The source of the insurer's notice or knowledge of a claim becoming disabling may come in the form of a physician's report indicating disability due to the compensable condition(s).

(3) Failure of the insurer or self-insured employer to respond timely to a request may result in penalties pursuant to OAR 436-030-0580.

(4) Except for reconsideration, pursuant to OAR 436-030-0115, the department or insurer shall not reclassify claims from disabling to nondisabling more than one year after the date of injury.

[(4)] **(5)** No claim shall be reviewed for initial reclassification unless the request or notice to an insurer that a nondisabling injury is or originally was disabling is made within one year of the date of injury.

[(5)] **(6)** Where an insurer or self-insured employer is ordered, after one year from the date of injury, to accept a claim by the Hearings Division or the insurer or self-insured employer does not respond to the worker's request until after one year from the date of injury and the worker has made a request to review the nondisabling status within one year of the date of injury, the department shall proceed with the review upon receiving notice and evidence of the timely request for review from the worker or worker's representative.

[(6)] **(7)** Upon receipt of a request by a party other than the insurer to review the status of

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a nondisabling claim, the department shall request all medical, vocational reports and all other applicable evidence from the insurer's claim file.

[(7)] **(8)** Information requested by the department shall be submitted by the insurer within 14 days of the request. Failure by the insurer to submit the information timely may result in penalties pursuant to OAR 436-030-0580.

[(8)] **(9)** Upon receipt of the information in the claim file, the department shall issue an order within the statutory period.

[(9)] **(10)** A claim is disabling if any of the following conditions apply:

(a) Temporary disability is due and payable;

(b) If the worker is medically stationary within one year of the date of injury and the worker will be entitled to an award of permanent disability under the standards developed pursuant to ORS 656.726;

(c) The worker is not medically stationary, but there is a reasonable expectation that the worker will be entitled to an award of permanent disability under the standards developed pursuant to ORS 656.726 when the worker does become medically stationary;

(d) The worker is released to and doing a modified job at reduced wages from the job at injury;

(e) If the modified job the worker is released to and doing at the wage of job at injury no longer exists or a job offer is withdrawn. This includes but is not limited to termination of temporary employment, layoff, or plant closure.

[(10)] **(11)** For claims that are reclassified, the aggravation rights begin with the first valid closure pursuant to ORS 656.268. For claims that are not reclassified, the aggravation rights continue to run from the date of injury.

[(11)] **(12)** Pursuant to ORS 656.277, claims for nondisabling injuries will be processed by the department in the same manner as claims for disabling injuries and if either party objects to the determination of the worker's disabling/nondisabling status by the department, that party must request a reconsideration by the department in accordance with ORS 656.268 before requesting a hearing pursuant to ORS 656.283.

Stat. Auth.: ORS 656.268, ORS 656.726 and 1995 OR Laws Chapter 332

Stats. Implemented: ORS 656.210, ORS 656.212, ORS 656.214, ORS 656.262, ORS 656.268, ORS 656.273, ORS 656.745, ORS 656.726 and 1995 OR Laws Chapter 332

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Amended 1/17/92 as WCD Admin. Order 5-1992, eff. 2/20/92.
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Amended 12/22/97 as WCD Admin. Order 97-065, eff. 1/15/98.

436-030-0055 Determining Permanent Total Disability

(1) A worker is permanently and totally disabled if permanently incapacitated from regularly performing work in a suitable and gainful occupation. For the purpose of this rule:

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(a) "Incapacitated" from regularly performing work means that the worker does not have the necessary physical and mental capacity and the work skills to perform work.

(b) "Suitable occupation" means those occupations that exist in a theoretically normal labor market, within a reasonable geographic distance, for which a worker has the training or experience, and abilities to realistically perform the job duties, with or without rehabilitation.

(c) "Gainful occupation" is defined as: those types of general occupations that pay wages equivalent to, or greater than, the state mandated hourly minimum wage. Those types of general occupations that pay on a commission or piece-work basis, as opposed to a wage or salary basis, may not be "gainful employment" depending upon the facts of the individual situation.

(d) "Work skills" as used in this rule means: those skills acquired through experience or training that are necessary to gain and adequately perform skilled, semi-skilled or unskilled occupations. Unskilled types of general occupations require no specific skills that would be acquired through experience or training to be able to gain and adequately perform the unskilled occupation. Every worker has the necessary work skills to gain and adequately perform unskilled types of general occupations with a reasonable period of orientation.

(e) A "reasonable geographic distance" as used in this rule means either of the following unless the worker is medically precluded from commuting:

(A) The area within a 60-mile radius of claimant's place of residence at the time of:

- (i) the original injury; or
- (ii) claimant's last gainful employment; or
- (iii) determination by the department; or
- (iv) reconsideration by the Appellate Unit.

(B) The area in which a reasonable and prudent uninjured and unemployed person, possessing the same physical capacities, mental capacities, work skills and financial obligations as claimant does at the time of his rating of disability, would go to seek work.

(f) "Types of general occupations" as used in this rule means: groups of jobs which exist in a theoretically normal labor market, and share similar vocational purpose, skills, duties, physical circumstances, goals, and mental aptitudes. It does not refer to any specific job or place of employment for which a job or job opening currently exists.

(g) "Theoretically normal labor market" as used in OAR 436-030-0055 and 0065 means a labor market that is undistorted by such factors as local business booms and slumps or extremes of the normal cycle of economic activity or technology trends in the long-term labor market.

(2) Disability which existed before the injury shall be included in determining permanent total disability.

(3) In order for a worker to be determined permanently and totally disabled, a worker must:

- (a) prove permanent and total disability;

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(b) make reasonable effort to find work at a suitable and gainful occupation or actively participate in a vocational assistance program, unless medical or vocational findings, including the residuals of the compensable injury, make such efforts futile; and

(c) be willing to seek regular and gainful employment.

(4) When a worker retains some residual functional capacity and is not medically permanently and totally disabled, the worker must prove inability to regularly perform work at a gainful and suitable occupation, and the futility of seeking work if claimant has not made reasonable work search efforts, by competent written vocational testimony. Competent written vocational testimony is that which is available at the time of closure or reconsideration and comes from the opinions of persons fully certified by the State of Oregon to render vocational services. It does not include opinions by claimants, physicians or others not certified.

(5) [Every] Determination Order(s) and **Orders on Reconsideration** which grant[s] permanent total disability shall notify the worker that:

(a) The claim shall be reexamined by the insurer at least once every two years, and may be reviewed more often if the insurer chooses.

(b) The insurer may require the worker to provide a sworn statement of the worker's gross annual income for the preceding year. The worker shall make the statement on a form provided by the insurer in accordance with the requirements under section (6) of this rule.

(6) If asked to provide a statement under subsection (5)(b) of this rule, the worker is allowed 30 days to respond. Such statements are subject to the following:

(a) If the worker fails to provide the requested statement, the director [shall] **may** suspend the worker's permanent total disability benefits. Benefits [may] **shall** be resumed when the statement is provided. Benefits not paid for the period the [report] **statement** was withheld shall be recoverable for no more than one year from the date of suspension.

(b) If the worker provides a report which is false, incomplete or inaccurate, the insurer shall investigate. The investigation may result in suspension of permanent total disability benefits.

Stat. Auth.: ORS 656.268, ORS 656.726 and 1995 OR Laws Chapter 332

Stats. Implemented: ORS 656.206, ORS 656.268, ORS 656.726 and 1995 OR Laws Chapter 332

Hist: Filed 12/17/87 as WCD Admin. Order 13-1987, eff. 1/1/88.
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Amended 2/14/96 as WCD Admin. Order 96-052, eff. 2/17/96.
Amended 12/22/97 as WCD Admin. Order 97-065, eff. 1/15/98.

436-030-0065 Review of Permanent Total Disability Awards

(1) The insurer shall reexamine each permanent total disability claim every two years or when requested to do so by the director to see if the worker is capable of regularly performing a suitable and gainful occupation. Reexamination of a PTD claim may be performed by the insurer whenever the insurer considers it necessary. Once an insurer has obtained the statutory three medical examinations for an open period and wants an additional medical examination on a PTD claim more frequently than every two years, the insurer is required to notify and request authorization from the director for the additional medical examination. The insurer shall send

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the results of the reexamination to the department. Workers who fail to cooperate with the reexamination [shall] **may** have benefits suspended, pursuant to OAR 436-060-0095, until such time as the worker cooperates with the reexamination.

(2) Any request from the insurer to the department to reduce permanent total disability shall be accompanied by documentation to support the request. That documentation shall include: medical reports, including all information necessary to rate the extent of permanent partial disability, vocational and/or investigation reports (including visual records, if available) which demonstrate the worker's ability to regularly perform a suitable and gainful occupation, and all other applicable evidence. The insurer shall notify the worker, and the worker's attorney, if represented, when requesting a reduction in permanent total disability benefits.

(3) An award of permanent total disability for scheduled injuries before July 1, 1975, shall be considered for reduction by the department only when the insurer provides evidence that the medical condition has improved.

(4) Except for section (3) of this rule, an award of permanent total disability shall be considered for reduction by the department when the insurer provides evidence that the worker is regularly working at a suitable and gainful occupation or is capable of doing so.

(5) Upon receipt of a request for reduction of permanent total disability, all evidence to support the request and all information sufficient to determine the extent of permanent partial disability, pursuant to section (2) of this rule, the department shall issue either a Determination Order reducing the permanent total disability and stating the extent of permanent partial disability or issue a Determination Order affirming the permanent total disability status.

(6) Any party to the claim who does not agree with the **Determination Order** [of the department] **may, within the statutory period, appeal the order pursuant to OAR 436-030-0007.**;

(a) Request reconsideration by the department if the worker became medically stationary on or before July 1, 1990, or request a hearing by writing to the Hearings Division of the Workers Compensation Board within 180 days after the mailing date of the order; or

(b) If the worker became medically stationary after July 1, 1990, must first request reconsideration by the department pursuant to these rules.

(7) Any party who disagrees with the reconsideration order may request a hearing from the Worker's Compensation Board, Hearings Division. Requests for hearing must be made in writing to the Workers' Compensation Board within 30 days after the mailing date of the reconsideration order.]

Stat. Auth.: ORS 656.268, ORS 656.726 and 1995 OR Laws Chapter 332

Stats. Implemented: ORS 656.206, ORS 656.214, ORS 656.268, ORS 656.283, ORS 656.319, ORS 656.325, ORS 656.331, ORS 656.726 and 1995 OR Laws Chapter 332

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 Amended 2/14/96 as WCD Admin. Order 96-052, eff. 2/17/96.
Amended 12/22/97 as WCD Admin. Order 97-065, eff. 1/15/98.

436-030-0066 Review of Prior Unscheduled Permanent Partial Disability Awards

(1) An award for unscheduled permanent partial disability is subject to periodic examination and adjustment pursuant to ORS 656.268 and 656.325 and in accordance with the following conditions:

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(a) Requests for review and adjustment shall be made in writing to the Workers' Compensation Division, 350 Winter Street NE, Salem, OR 97310.

(b) The party requesting review of permanent disability shall inform the affected parties at the same time of the request. The worker may submit any information in rebuttal.

(c) All pertinent medical, vocational, and other applicable evidence shall be submitted with the request, including information sufficient to determine the extent of permanent partial disability. The request must state the basis for the request and provide supporting evidence. If the director finds that the worker has failed to accept treatment as provided in this rule, the department shall make any necessary adjustments pursuant to OAR 436-035-0270 through 436-035-0450.

(d) The basis for the request for adjustment in the disability award shall be failure of the worker to make a reasonable effort to reduce the disability and be so stated in the request for adjustment.

[(2) The department shall issue a Determination Order within 20 working days of receipt of a complete request, allowing 10 working days for the worker to respond to the notice of a request for adjustment in permanent disability.]

Stat. Auth.: ORS 656.268, ORS 656.726 and 1995 OR Laws Chapter 332

Stats. Implemented: ORS 656.325, ORS 656.331, ORS 656.268, ORS 656.726 and 1995 OR Laws Chapter 332

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Amended 2/14/96 as WCD Admin. Order 96-052, eff. 2/17/96.
Amended 12/22/97 as WCD Admin. Order 97-065, eff. 1/15/98.

436-030-0115 Reconsideration of Determination Orders or Notices of Closure

(1) A Determination Order shall be reconsidered by the department [upon] **after** receipt of a written request for reconsideration by the worker, the worker's representative, or the insurer(s). **The request must be mailed to the department within the statutory appeal period. To begin the reconsideration proceeding, the party which did not initially request reconsideration must:**

(a) file a cross-request for reconsideration; or

(b) waive their right to request reconsideration; or

(c) allow the appeal period to expire, in which case the reconsideration proceeding will begin on the 61st day after the closure or order.

(2) A Notice of Closure shall be reconsidered by the department upon receipt of a written request for reconsideration by the worker or the worker's representative. **The reconsideration proceeding begins upon receipt of the request.** The request must be mailed **to the department** within the statutory appeal period as defined in OAR 436-030-0005[(10)](9).

[(2)] (3) For the purpose of these rules, "reconsideration proceeding" means the procedure established to reconsider a Notice of Closure or Determination Order and does not include personal appearances by any of the parties to the claim or their representatives, unless requested by the department. All information to correct or clarify the record and any medical evidence regarding the [claimant] **worker's** condition as of the time of claim closure that should have been

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but was not submitted by the physician serving as the attending physician at the time of claim closure and all supporting documentation must be presented during the reconsideration proceeding. When the reconsideration proceeding is postponed because the worker's condition is not medically stationary under OAR 436-030-0165[(6)(a)] **(9)**, medical evidence submitted may address the [claimant's] **worker's** condition after claim closure as long as the evidence satisfies the conditions of OAR 436-030-0145(3)(c).

[(3)] **(4)** All parties have an opportunity to submit documents to the record regarding the worker's status at the time of claim closure. Other factual information and written argument may be submitted for incorporation into the record pursuant to ORS 656.268 (6) within the time frames outlined in OAR 436-030-0145. Such information may include, but is not limited to, responses to the documentation and written arguments[of the opposing party], written statements and sworn affidavits from the parties.

[(4)] **(5)** Only one reconsideration proceeding may be completed on each Determination Order or Notice of Closure and the department will do a complete review of that [closure] **notice or order**. Once the reconsideration proceeding is appropriately initiated by one party, the opposing party(**ies**) must use or lose this opportunity to introduce additional issues and evidence for review by the director or to file a cross-request for reconsideration within the time frames allowed for processing the [first timely] reconsideration request. When the department determines that there has been insufficient time for the parties to submit necessary information to complete the record, the reconsideration proceeding may be postponed pursuant to ORS 656.268(6)(b).

[(5)] **(6)** Pursuant to OAR 436-030-000[8] **7**(1), at the director's discretion, an Order on Reconsideration can be abated, withdrawn and/or amended.

Stat. Auth.: ORS 656.726(3)(a)

Stats. Implemented: ORS 656.268(4)(e), (5)(b), (9), (11)

Hist: Filed 6/30/78 as WCD Admin. Order 8-1978, eff. 7/10/78.
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 Renumbered from OAR 436-65-100, May 1985.
 Amended 12/17/87 as WCD Admin. Order 13-1987, eff. 1/1/88.
 Amended 6/18/90 as WCD Admin. Order 7-1990, eff. 7/1/90, (temp.).
 Amended 12/10/90 as WCD Admin. Order 33-1990, eff. 12/26/90.
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 Amended 2/14/96 as WCD Admin. Order 96-052, eff. 2/17/96.
Amended 12/22/97 as WCD Admin. Order 97-065, eff. 1/15/98.

436-030-0125 Reconsideration Form and Format

(1) The director shall by Bulletin prescribe the form and format of a completed request for reconsideration. Pursuant to this section, a "completed reconsideration request" shall include, but not be limited to:

- (a) the Worker's Name, [Social Security Number,] Date of Injury and WCD File Number;
- (b) a statement in bold face print, "REQUEST FOR RECONSIDERATION";
- (c) the date of closure, type of closure and the specific reason(s) for objection to the Determination Order or Notice of Closure;
- (d) the name of the worker's attorney (if any);

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(e) the name of the insurer's attorney (if any);

(f) whether there is disagreement with the specific impairment findings used to determine permanent disability at the time of claim closure and if so, an explanation is required of the specific areas of disagreement;

(g) any information and documentation deemed necessary to correct or clarify any part of the claim record the party believes to be erroneous; and/or

(h) any medical evidence that should have been but was not submitted at the time of the claim closure including clarification or correction of the medical record based on the examination(s) at or before claim closure;

(i) in accordance with OAR 436-030-0135, a signed certification, submitted with the reconsideration request, that states the party requesting a reconsideration has provided copies of the request plus supporting evidence to all other interested parties; and,

(j) a statement in bold face print:

Note to the Worker: A reconsideration **includes a review of the whole order and** may result in a decrease or an increase of your benefits.

Notice to Parties: The worker or the insurer may correct information in the record that is erroneous and may submit any medical evidence that should have been but was not submitted by the physician serving as the attending physician at the time of claim closure (ORS 656.268).

This is the only reconsideration proceeding by the Appellate Review Unit for this claim closure. [Either] **All** part[y] **ies** ha[s] **ve** an opportunity to raise issues and provide evidence for consideration, or to file a cross-request for reconsideration within the **statutory** time frames [allowed for the first timely reconsideration request]. You [must] **may** identify additional issues, submit any additional information, or provide your cross-request for reconsideration to the Appellate Review Unit, Workers' Compensation Division, 350 Winter Street N.E., Salem, Oregon 97310 [within ten (10) working days from the date the request for reconsideration is received by the department].

Stat. Auth.: ORS 656.726(3)(a)

Stats. Implemented: ORS 656.268(4)(e), (5)(b), (9), (11)

Hist: Filed 6/18/90 as WCD Admin. Order 7-1990, eff. 7/1/90, (temp.).
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Amended 1/17/92 as WCD Admin. Order 5-1992, eff. 2/20/92
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436-030-0135 Reconsideration Procedure

(1) When requesting reconsideration of a Notice of Closure or Determination Order, an insurer and a worker represented by an attorney must submit a "completed reconsideration request," pursuant to OAR 436-030-0125 and, at the same time, provide copies of the completed request to the other interested parties:

(a) [The notice to the parties] **When providing copies to other interested parties, they must be advised** [them] that the reconsideration proce[eding] **ss** for the [claim closure] **Notice of Closure or Determination Order** has be[gun] **en requested**, of their right to **identify issues, submit and**

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correct information in the record, and of the time frames for submitting such information in accordance with OAR 436-030-0145.

(b) The requesting party must certify, by means of a signed statement, submitted with the reconsideration request, that copies of the "completed reconsideration request" were provided to all other interested parties. This is the sole means of notifying other interested parties that a reconsideration request has been filed. When the requesting party fails to comply with this rule, the department will not consider any correcting or clarifying evidence submitted with the reconsideration request, and such evidence will not be part of the record on reconsideration.

(c) If, within 10 working days from the [request for] **beginning of the reconsideration proceeding**, the noncomplying party subsequently certifies to the department that other interested parties have received copies of the appropriate information, the additional information will be considered in the reconsideration proceeding.

(d) All information submitted to the department by any interested party during the reconsideration process must be copied to all interested parties and be accompanied by certification that it has been provided to all interested parties. Failure to comply with this requirement will result in the information not being included as part of the record on reconsideration.

(e) When a party does not discover until after the reconsideration order has issued that additional documents were not provided by the opposing party in accordance with this rule, the Order on Reconsideration may be abated and withdrawn to give the party an opportunity to respond to the new information.

(2) Upon receipt of a request from an unrepresented worker, the department shall assist the worker in developing a completed request; inform the worker of the right to consult with the ombudsman or an attorney; and mail a copy to the insurer. Notwithstanding any other provision of this rule, the department may extend any nonstatutory time frames or request any information deemed necessary to assure the unrepresented worker's reconsideration request is complete.

(3) Upon receipt of a request for reconsideration **on a Determination Order**, the department will advise all parties **of the date the request was received and the options available to initiate the reconsideration proceeding, pursuant to OAR 436-030-0115.**

(4) At the beginning of the reconsideration proceeding, the department will advise all parties the request was received and of the time lines for submitting additional information. The acknowledgment letter shall include a certification of service verifying that the letters have been mailed to the parties listed. The department will [also] notify the parties of the last date an Order on Reconsideration can be issued and the status of their request if the department fails to mail a reconsideration order pursuant to the time limits specified in ORS 656.268(6).

[⁽⁴⁾](5) The insurer shall furnish within 10 working days of the [mailing date] **beginning** of the reconsideration [request made by the worker or the worker's representative] **proceeding**, the following copies without cost:

(a) for a Notice of Closure, all documents pertaining to the claim, **that have not been**

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previously submitted, shall be furnished to the department and the worker or the worker's representative;

(b) for a Determination Order, any documents [supplemental to the Determination Order shall be furnished] that have not been previously submitted to the department and the worker or the worker's representative as well as other documents as requested by the department or the worker or the worker's representative.

[(5)](6) When a worker has received a lump sum payment, pursuant to ORS 656.230, of an award granted by a Notice of Closure or Determination Order, the department shall not consider the adequacy of that award in a reconsideration proceeding.

[(6)](7) When the department finds, upon reconsideration, that the claim was closed prematurely by failing to meet the requirements of OAR 436-030-0015, 436-030-0020, 436-030-0030, 436-030-0034 or 436-030-0035, the department [shall] may issue an order rescinding the Notice of Closure or Determination Order.

(8) Upon reconsideration, when a new condition is accepted after claim closure that was medically stationary at the time of claim closure, the department shall determine:

(a) if the insurer will process to closure, then the newly accepted condition will not be considered in the reconsideration proceeding; OR

(b) if the newly accepted condition will be processed at reconsideration; inclusion of the newly accepted condition at reconsideration will be considered a reopening and closure pursuant to ORS 656.262(7);

(c) if the newly accepted condition was reopened and closed before the reconsideration began, by mutual agreement the parties may consolidate the closures into one reconsideration proceeding.

[(7)](9) The reconsideration order shall address issues raised by the parties and shall address compensation as follows:

(a) C[c]ompensation reduced in a reconsideration order shall be "in lieu of" any compensation awarded by the Notice of Closure or Determination Order.

(b) A[a]dditional compensation awarded in a reconsideration order shall be "in addition to" any compensation awarded by the Notice of Closure or Determination Order. The reconsideration order may award total compensation due less any compensation previously ordered.

(c) A[a]ny compensation affirmed in a reconsideration order shall be so stated.

(d) T[t]he dollar rate per degree of disability shall be listed.

[(8)](10) A copy of the reconsideration order will be sent to the worker, employer(s), insurer(s), worker's attorney if the worker is represented, and the insurer's attorney(s), if the insurer is represented.

Stat. Auth.: ORS 656.726(3)(a)

Stats. Implemented: ORS 656.268(6)

Hist: Filed 6/30/78 as WCD Admin. Order 8-1978, eff. 7/10/78.

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436-030-0145 Reconsideration Time Frames and Postponements

(1) For claims with a medically stationary date prior to June 7, 1995, the time required to complete the reconsideration proceeding pursuant to this rule shall not be included in the 180 days from the mailing date of the Notice of Closure or Determination Order to request a hearing.

(a) The 180-day time limit will be tolled upon receipt of the request for reconsideration from the mailing date of the request for reconsideration until the reconsideration request is either dismissed or an Order on Reconsideration is issued.

(b) The 180-day time limit will be tolled for all parties upon the request for reconsideration [of either] **from any** party.

(c) The 180-day time limit will not be tolled when a request for reconsideration is withdrawn by the parties pursuant to OAR 436-030-0185.

(2) For claims with a medically stationary date, or date the claim statutorily qualifies for closure, on or after June 7, 1995, a request for reconsideration shall be mailed within 60 days of the mailing date of the Determination Order or Notice of Closure. A request for hearing must be made within 30 days of the mailing date of the **Order on** Reconsideration[Order].

(3) Ten working days after the date the [request for] reconsideration [is received] **proceeding begins**[by the director], the **reconsideration** request and all other appropriate information submitted by the parties shall become part of the record used in the reconsideration proceeding.

(a) Evidence received or issues raised subsequent to the tenth [(10)] working day deadline will be considered in the reconsideration proceeding to the extent practicable.

(b) Upon review of the record the department may request, in accordance with ORS 656.268(6)(b), any additional information deemed necessary for the reconsideration and set appropriate time frames for response.

(c) When the reconsideration proceeding has been postponed in accordance with OAR 436-030-0165[(6)(a)]**(9)** because the worker's condition is not medically stationary, interim medical information that may be helpful to the director and the medical arbiter in assessing and describing the impairment due to the compensable condition(s) may be submitted at the time the parties notify the director that the medical arbiter can be scheduled. The director will determine whether the interim medical information is consistent with the provisions of ORS 656.268(6)(a) and (7)(h).

[(4)]**(d) Except as provided in section (4) of this rule, t**[T]he department will either mail an Order on Reconsideration within 18 working days [after]**from** the date the reconsideration [request was received]**proceeding begins** or [it will] notify the parties that the reconsideration proceeding

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is postponed for not more than 60 additional days in accordance with the provisions of ORS 656.268(6).

(4) Pursuant to ORS 656.268(7)(d), when the director provides notice the worker failed to attend the medical arbiter examination without good cause or failed to cooperate with the arbiter examination and suspends benefits, the reconsideration proceeding will be postponed for up to 60 additional days from the date the director determines and provides notice, to allow completion of the arbiter process.

(5) Pursuant to ORS 656.726(3)(f)(C), the reconsideration proceeding may be stayed to determine whether temporary rules amending "the standards" are required to properly rate the worker's impairment. The department will notify the parties that the proceeding has been stayed for this purpose.

(6) Pursuant to ORS 656.236 when a Claims Disposition Agreement (CDA) is filed with the Board, the reconsideration proceeding is stayed until a CDA is either approved by a final order of the Workers' Compensation Board or the Board sets aside the disposition. The department will notify the parties that the proceeding has been stayed for this purpose.

(7) If the department fails to mail an Order on Reconsideration or a Notice of Postponement pursuant to the time frames specified in ORS 656.268(6), the reconsideration request is automatically deemed denied. The parties may immediately thereafter proceed as though the department had issued an Order on Reconsideration affirming the Notice of Closure or the Determination Order. In accordance with section (1) of this rule, the counting of the 180-day time limit for requesting a hearing under former ORS 656.268(6)(b) shall resume on the date after the department should have issued an Order on Reconsideration.

(8) Notwithstanding any other provision regarding the reconsideration proceeding, the department may extend nonstatutory time frames to allow the parties sufficient time to present evidence and address their issues and concerns.

Stat. Auth.: ORS 656.726(3)(a)

Stats. Implemented: ORS 656.268(1); 656.268(6)(a), (b), (d); 656.726(3)(f)(C)

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Amended 12/22/97 as WCD Admin. Order 97-065, eff. 1/15/98.

436-030-0155 Reconsideration Record

(1) The record [used in] **for** the reconsideration proceeding shall include [the] **all** documents **and other material** relied upon in issuing the Order on Reconsideration as well as any additional material submitted **by the parties,** but not considered [relevant to] **in** the reconsideration proceeding. The record shall be maintained in the Workers' Compensation Division's claim file and shall [include] **consist of** all documents **and material received and** date stamped prior to the issuance of the **Order on R**[r]econsideration [order]. The medical record submitted **by the**

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department [to the medical] **for** arbiter [physician is] **review will consist of** all [medical records deemed relevant] **documents and material found pertinent** [to] **in** determin[e] **ing the worker's** impairment findings for the closure under reconsideration. [For identification purposes,] **Those documents composing** the medical record [is stamped] **will have** "medical arbiter" **stamped** in the lower right hand corner.

(2) The record used to close the claim is developed by the insurer. The insurer is required to provide the department and the other party **(ies)** with a copy of all documents contained in the record at claim closure.

(3) The documents added to the claim closure record at the reconsideration proceeding are submitted to the department by [either] **the part[y]ies**. By rule, the parties are also required to send copies of all information submitted at the reconsideration proceeding to the [opposing] **other interested part[y]ies**.

(4) Any information the department adds to the record, such as the medical arbiter report, is copied to all parties. **Responses of the parties to the medical arbiter report shall be included in the record if received prior to completion of the reconsideration proceeding.**

(5) Since [both] **all** parties have a complete copy of the record at reconsideration prior to the issuance of a reconsideration order, additional certified copies of the record will be made at a charge to the requesting party.

(6) When a hearing is scheduled following the appeal of a reconsideration order and the parties or the administrative law judge requests the director to provide the record at reconsideration, either the original claim file or a certified copy of the claim file will be delivered to the Hearings Division two days prior to the hearing. The original claim file shall be returned to the director within two days after the hearing.

Stat. Auth.: ORS656.726(3)(a)

Stats. Implemented: ORS656.268(6)

Hist: Filed 6/30/78 as WCD Admin. Order 8-1978, eff. 7/10/78.
Amended 3/20/80 as WCD Admin. Order 4-1980, eff. 4/1/80.
Renumbered from OAR 436-65-100, May 1985.
Amended 12/17/87 as WCD Admin. Order 13-1987, eff. 1/1/88.
Amended 6/18/90 as WCD Admin. Order 7-1990, eff. 7/1/90, (temp.).
Amended 12/10/90 as WCD Admin. Order 33-1990, eff. 12/26/90.
Amended 8/20/91 as WCD Admin. Order 6-1991, eff. 9/01/91 (temp.).
Amended 1/17/92 as WCD Admin. Order 5-1992, eff. 2/20/92
Amended and renumbered from OAR 436-030-0050, 11/18/94 as WCD Admin. Order 94-059, eff. 1/1/95.
Amended 2/14/96 as WCD Admin. Order 96-052, eff. 2/17/96.
Amended 12/22/97 as WCD Admin. Order 97-065, eff. 1/15/98.

436-030-0165 Medical Arbiter Examination Process

(1) When a basis for the Request for Reconsideration is a disagreement with the impairment findings used in rating the worker's disability at the time of claim closure, the director shall refer the claim to a medical arbiter or panel of arbiters.

(a) When the director determines that sufficient medical information is not available to rate disability pursuant to ORS 656.268(7), the director may refer the claim to a medical arbiter or panel of arbiters.

(b) The department will notify the parties within 18 working days from the date the

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reconsideration [request was received] **proceeding begins** that a medical arbiter review will be scheduled.

(c) The parties may not be granted their request for an arbiter examination or a change from a single arbiter to a panel of arbiters if the request is received after the tenth [(10)] working day from [receipt of] **the date** the reconsideration [request by the director] **proceeding begins**.

(d) When the director requests clarification, a party's failure to provide an explanation may preclude a medical arbiter review if a preponderance of medical evidence at the time of claim closure does not raise an issue regarding the validity of the closing examination.

(e) The costs related to record review, examinations and reports of the medical arbiter shall be paid pursuant to OAR 436-[010-0047]**009-0020**.

(2) The director shall select a medical arbiter physician or a panel of physicians from a list of physicians qualified to be attending physicians who are licensed pursuant to ORS 656.005(12)(b)(A). Arbiters or panel members shall not include any providers whose examination or treatment is the subject of the review.

(a) Any party that objects to a physician on the basis that the physician does not qualify in one of the areas described in section (2) of this rule, must notify the director prior to the examination of the specific objection. If the director determines that the physician is not qualified to be a medical arbiter on the specific case, an examination will be scheduled with a different physician. All costs related to the completion of the medical arbiter process in this rule shall be paid by the insurer.

(b) When the worker resides outside the state of Oregon, a medical arbiter examination may be scheduled out-of-state with a physician who is licensed within that state to provide medical services in the same manner as required by ORS 656.268(7).

(3) The medical arbiter or panel of medical arbiters shall perform a record review or examine the worker as requested by the director and perform such tests as may be reasonable and necessary to establish the worker's impairment. The director shall provide notice of the examination of the worker to all parties.

(a) Any issues the parties wish the medical arbiter or panel of medical arbiters to address must be submitted to the department within 10 working days after the date the reconsideration [request is received by the director] **proceeding begins**. No issues should be submitted to the medical arbiter or panel of medical arbiters directly by the parties. Only issues appropriate to the reconsideration proceeding will be submitted by the department to the medical arbiter or panel of medical arbiters.

(b) The medical arbiter or panel of medical arbiters shall address all questions raised by the department in the report. Issues raised directly to the medical arbiter by the parties shall not be addressed in the medical arbiter report.

(c) The department shall instruct the medical arbiter to provide copies of the arbiter report to the department, the worker or the worker's representative, and the insurer(s) within 5 working days after completion of the arbiter review. The cost of providing copies of such additional reports shall be reimbursed according to OAR 436-[010-0090]**009-0020** and shall be paid by the

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insurer.

(4) The department shall notify the parties of the time and place of the medical arbiter examination. This notice shall also inform the worker that failure to attend the medical arbiter examination or to cooperate with the medical arbiter will result in suspension of all disability benefits effective on the date of the examination unless the worker establishes a "good cause" reason for missing the examination or for not cooperating with the arbiter. The appointment letter shall instruct the worker to call the department within 24 hours after failing to attend the examination to provide any "good cause" reason for missing the exam.

(a) [(5) When the director refers the claim to a medical arbiter or panel of arbiters and the worker fails to appear for the medical arbiter exam without good cause, or fails to cooperate with the medical arbiter, the director shall suspend disability benefits effective on the date of the missed examination.] Notice of the examination shall be considered adequate notice if the appointment letter is mailed to the last known address of the worker and, when appropriate, to the worker's representative.

(b) For the purposes of this rule, "does not cooperate with the examination" includes, but is not limited to, refusal to complete any reasonable action necessary to evaluate the worker's impairment. However, it does not include circumstances such as a worker's inability to carry out any part of the examination due to excessive pain or when the physician reports the findings as medically invalid.

(c) Failure of the worker to respond within the time frames outlined in statute for completion of the reconsideration proceeding may be considered a failure to establish "good cause".

[(a) The reconsideration proceeding is deferred during the time a worker's disability benefits are suspended and the time during the suspension shall not be counted in the time allowed to complete the reconsideration.

(b) When the suspension order is issued and the reconsideration proceeding is deferred, any written request by the worker to reschedule the medical arbiter examination must be mailed within 30 days after the suspension order is issued. If a request to reschedule the medical arbiter examination is not mailed within 30 days and the worker has not appealed the suspension order, the director shall order the suspension removed and:]

(5) If a worker misses the medical arbiter examination, the director shall determine whether or not there was a "good cause" reason for missing the examination.

(6) Upon determination that there was not a "good cause" reason for missing the examination, or that the worker had failed to cooperate with the arbiter, the director will issue a notice to the worker that disability benefits are suspended and that the reconsideration proceeding is postponed up to an additional 60 days. A rescheduled examination will be made for the worker to complete the medical arbiter review within the additional 60-day postponement period.

(7) As addressed in the Order on Reconsideration, the suspension will be lifted if any of the following occurred during the additional 60-day postponement period:

(a) The worker established a "good cause" reason for missing or failing to cooperate with the examination; or

(b) The request for reconsideration was withdrawn by all the requesting parties; or

(c) The worker attended and cooperated with a rescheduled arbiter examination.

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(8) If none of the events which end the suspension pursuant to subsection (7) of this rule occurred prior to the expiration of the 60-day additional postponement, the director shall complete the reconsideration proceeding pursuant to ORS 656.268(7)(d) and the Order on Reconsideration will order the suspension of benefits to remain in effect.

[(A) When the reconsideration proceeding was requested by the worker, determine that by not completing the medical arbiter examination, the worker has effectively withdrawn the reconsideration request, and the director shall dismiss the reconsideration proceeding with prejudice, or;

(B) When the reconsideration was requested by the insurer, inquire whether the insurer intends to withdraw the reconsideration request. If the insurer does not withdraw the reconsideration request, the director will determine that the record is insufficiently documented to accurately rate permanent impairment and a rating of zero permanent disability will be awarded in the reconsideration order.

(c) If a worker fails to attend a post suspension order rescheduled medical arbiter examination and the worker did not appeal the suspension order, the director shall proceed as described in paragraph(s) (5)(b)(A) and/or (B) of this rule

(d) If the worker disagrees with the suspension order, a request for contested case hearing must be made in writing to the Administrator of the Workers' Compensation Division within 30 days from the issuance of the suspension order. If the suspension order is reversed at hearing and it is determined that the worker had "good cause" for failure to attend or cooperate with the medical arbiter process, the director may reschedule a medical arbiter examination which the worker is obligated to attend so that the reconsideration proceeding can be completed. If the suspension order is affirmed at hearing, a written request by the worker to reschedule the medical arbiter examination must be mailed within 30 days of the director's order or the director shall proceed as described in paragraph(s) (5)(b)(A) and/or (B) of this rule. If the contested case order affirming the suspension is appealed, then a written request by the worker to reschedule the medical arbiter examination must be mailed within 30 days after any appealed order becomes final by operation of law or the director shall proceed as described in paragraph(s) (5)(b)(A) and/or (B) of this rule.]

[(6)] **(9)** When a medical arbiter examination is not medically appropriate because the worker's medical condition is not stationary and impairment cannot be accurately evaluated by the physician, the director will send a letter to the parties requesting consent to postpone the reconsideration proceeding pursuant to ORS 656.268(7)(h).

(a) If the parties agree to the postponement, the reconsideration proceeding will be postponed until the worker's condition has medically resolved to allow for examination. The parties must notify the director when it is appropriate to schedule the medical arbiter examination.

(b) If the parties do not agree to the postponement, at the director's discretion either a medical arbiter examination or a medical arbiter record review may be obtained.

(c) If no medical arbiter exam or review is obtained, the closure will be reconsidered based on the record available at claim closure including information obtained pursuant to ORS 656.268(6).

Stat. Auth.: ORS 656.726(3)(a)

Stats. Implemented: ORS 656.268(7)

Hist: Filed 6/18/90 as WCD Admin. Order 7-1990, eff. 7/1/90, (temp.).
Amended 12/10/90 as WCD Admin. Order 33-1990, eff. 12/26/90.
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Amended 1/17/92 as WCD Admin. Order 5-1992, eff. 2/20/92
Amended and renumbered from OAR 436-030-0050, 11/18/94 as WCD Admin. Order 94-059, eff. 1/1/95.
Amended 8/23/95 as WCD Admin. Order 95-059, eff. 8/23/95 (temp).
Amended 2/14/96 as WCD Admin. Order 96-052, eff. 2/17/96.
Amended 12/22/97 as WCD Admin. Order 97-065, eff. 1/15/98.

436-030-0175 Fees and Penalties within the Reconsideration Proceeding

(1) An insurer failing to provide information or documentation as set forth in OAR 436-030-0135, 0145 and 0165 may be assessed civil penalties pursuant to OAR 436-030-0580. Failure to comply with the requirements set forth in OAR 436-030-0135, 0145 and 0165 may

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also be grounds for extending the reconsideration proceeding pursuant to ORS 656.268(6).

(2) If upon reconsideration of a Notice of Closure there is an increase of 25 percent or more in the amount of permanent disability compensation from that awarded by the Notice of Closure, and the worker is found to be at least 20 percent permanently disabled, the insurer shall be ordered to pay the worker a penalty equal to 25 percent of the increased amount of permanent disability compensation. If an increase in compensation results from the promulgation of a temporary emergency rule, penalties will not be assessed. For claims with medically stationary dates or statutory closure dates on or after June 7, 1995, if the increase in compensation results from new information obtained through a medical arbiter examination, the penalty shall not be assessed.

(3) For the purpose of section (2) of this rule, a worker who receives a total sum of 64 degrees of scheduled or unscheduled disability or a combination thereof, shall be found to be at least 20 percent disabled. As an illustration, a worker who receives 20 percent disability of a great toe (3.6 degrees) is not considered 20 percent permanently disabled because the great toe is only a portion of the whole person. A worker who is 100 percent permanently disabled is entitled to 320 degrees of disability. A worker who receives 64 degrees (20 percent of 320 degrees), whether scheduled, unscheduled or a combination thereof, shall be considered the equivalent of at least 20 percent permanently disabled for the purposes of this rule.

(4) Attorney fees may only be authorized when a Request for Reconsideration is submitted by an attorney representing a worker or the attorney provides documentation of representation, and a valid signed retainer agreement has been filed with the department. The reconsideration order shall order the insurer to pay the attorney 10 percent out of any additional compensation awarded but not more than the maximum attorney fee allowed in OAR 438-015-0040(1) and (2) and OAR 438-015-0045, effective January 1, [1996] **1997. "Additional compensation" includes an increase in a permanent or temporary disability award.**

Stat. Auth.: ORS 656.726(3)(a)

Stats. Implemented: ORS 656.268(4)(g), (6)(c)

Hist: Filed 6/18/90 as WCD Admin. Order 7-1990, eff. 7/1/90, (temp.).
Amended 12/10/90 as WCD Admin. Order 33-1990, eff. 12/26/90.
Amended 8/20/91 as WCD Admin. Order 6-1991, eff. 9/01/91 (temp.).
Amended 1/17/92 as WCD Admin. Order 5-1992, eff. 2/20/92
Amended and renumbered from OAR 436-030-0050, 11/18/94 as WCD Admin. Order 94-059, eff. 1/1/95.
Amended 8/23/95 as WCD Admin. Order 95-059, eff. 8/23/95 (temp).
Amended 2/14/96 as WCD Admin. Order 96-052, eff. 2/17/96.
Amended 12/22/97 as WCD Admin. Order 97-065, eff. 1/15/98.

436-030-0185 Reconsideration: Settlements and Withdrawals

(1) Contested matters arising out of a claim closure may be resolved by mutual agreement of the parties at any time after the claim has been closed under ORS 656.268 but before that claim closure has become final by operation of law. If the parties have reached such an agreement prior to the completion of the reconsideration proceeding, the parties shall submit the stipulation agreement to the director for approval as part of the reconsideration proceeding. The Stipulation for review at the reconsideration proceeding must:

(a) address only issues that pertain to a claim closure and cannot include any issues of compensability;

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(b) list the body part(s) for which any award is made and shall recite all disability awarded in both degrees and percent of loss when permanent partial disability is part of the stipulated agreement. In the event there is any inconsistency between the stated degrees and percent of loss awarded in any stipulated agreement, the stated percent of loss shall be controlling.

(2) The director shall review the Stipulation and issue an order within 18 working days from receipt of the Stipulation by the director. Stipulations approved by the director are not appealable.

(3) When the stipulated agreement does not expressly resolve all issues relating to the claim closure, the Order on Reconsideration will include the Stipulation as well as a substantial determination of all remaining issues. In these claims, the 18 working day time frame may be postponed in the same manner as any reconsideration proceeding.

(4) If the Stipulation is not approved, the reconsideration proceeding will be postponed to allow the parties to:

(a) address the disapproval, and/or

(b) to request that the department issue an Order on Reconsideration addressing the substantive issues.

(5) When the parties desire to enter into a stipulated agreement to resolve disputed issues relating to the claim closure but are unable to reach an agreement, the parties may request the assistance of the director to mediate an agreement.

(6) When the parties desire to enter a stipulated agreement that addresses issues including all matters being reconsidered as well as issues not before the reconsideration proceeding, and the parties do not want a reconsideration on the merits of the claim closure, they may advise the department of their resolution and request that the department enter an Order on Reconsideration affirming the Notice of Closure or Determination Order. The request for an affirming order must be made prior to the date an Order on Reconsideration is issued and in accordance with the following procedure:

(a) A written request for an affirming reconsideration order must be made by certified mail and be signed by both parties or their representatives. The written request must also state that the parties waive their right to an arbiter review, and that all matters subject to the mandatory reconsideration process have been resolved. A copy of the proposed stipulated agreement must accompany the request.

(b) After the affirming Order on Reconsideration has issued, the parties will submit their stipulation to a referee of the Hearings Division, Workers' Compensation Board, for approval in accordance with the provisions of ORS 656.289(1) and the Board's rules of practice and procedure.

(c) An Order on Reconsideration issued pursuant to this rule is final and is subject to review pursuant to ORS 656.283.

(d) This provision does not apply to Claims Disposition Agreements filed pursuant to

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ORS 656.236.

(7) A party requesting a reconsideration may withdraw the request for reconsideration if no response or additional information has been submitted by the other party(ies) and no medical arbiter exam has occurred. If information has been submitted by the other party(ies), or a medical arbiter exam has occurred, [both]all parties must agree to withdraw the reconsideration. When appropriate, an order withdrawing the reconsideration will be issued.

Stat. Auth.: ORS656.726(3)(a)

Stats. Implemented: ORS656.268(6)

Hist: Filed 6/18/90 as WCD Admin. Order 7-1990, eff. 7/1/90, (temp.).
Amended 12/10/90 as WCD Admin. Order 33-1990, eff. 12/26/90.
Amended 8/20/91 as WCD Admin. Order 6-1991, eff. 9/01/91 (temp.).
Amended 1/17/92 as WCD Admin. Order 5-1992, eff. 2/20/92
Amended and renumbered from OAR 436-030-0050, 11/18/94 as WCD Admin. Order 94-059, eff. 1/1/95.
Amended 2/14/96 as WCD Admin. Order 96-052, eff. 2/17/96.
Amended 12/22/97 as WCD Admin. Order 97-065, eff. 1/15/98.

436-030-0580 Penalties and Sanctions

(1) Pursuant to ORS 656.745, the director or designee may assess a civil penalty against an employer or insurer who fails to comply with the rules and orders of the director regarding reports or other requirements necessary to carry out the purposes of the Workers' Compensation Law.

(2) An insurer or medical provider failing to meet the [period and reporting] requirements set forth in OAR 436-030-0015, 436-030-0017, 436-030-0020, 436-030-0030, 436-030-0038, 436-030-0045, and 436-030-0125 through 436-030-0185 may be assessed a civil penalty.

(3) Pursuant to OAR 436-010-0[130] 340, the director may impose sanctions for any medical provider failing to meet the period and reporting requirements set forth in OAR 436-030-0030(7).

(4) In arriving at the amount of penalty, the director or designee may assess a penalty of up to \$2,000 for each violation or \$10,000 in the aggregate for all violations in any three-month period.

Stat. Auth.: ORS 656.268, ORS656.726 and 1995 OR Laws Chapter 332

Stats. Implemented: ORS656.268, ORS656.726, ORS656.745 and 1995 OR Laws Chapter 332

Hist: Filed 12/17/87 as WCD Admin. Order 13-1987, eff. 1/1/88.
Amended 12/10/90 as WCD Admin. Order 33-1990, eff. 12/26/90.
Amended 1/17/92 as WCD Admin Order 5-1992, eff. 2/20/92.
Amended 11/18/94 as WCD Admin. Order 94-059, eff. 1/1/95.
Amended 2/14/96 as WCD Admin. Order 96-052, eff. 2/17/96.
Amended 12/22/97 as WCD Admin. Order 97-065, eff. 1/15/98.

436-030-0581 Issuance/Service of Penalty Orders

(1) When a penalty is assessed as provided in OAR 436-030-0580, the director or designee shall serve an order on the party with a notice of the party's appeal rights provided under ORS 656.704.

(2) The Order shall be served by:

(a) mailing a copy of the Order to the party by certified mail return receipt requested. If the employer is a corporation, the certified mail may be addressed to any one of the persons

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named in Rule 7 of Oregon Rules of Civil Procedure subsection (D)(3)(b)(i); or

(b) delivering a copy to the party in the manner provided by Rule 7 of Oregon Rules of Civil Procedure, subsection (D)(2).

(3) Orders issued in accordance with these rules shall contain the following notice:

"IF YOU DISAGREE WITH THIS ORDER, YOU ARE ENTITLED TO A HEARING AS PROVIDED BY ORS 656.704(2), OAR 436-030-000[8]7, AND THE CONTESTED CASE PROVISIONS OF THE ADMINISTRATIVE PROCEDURES ACT (ORS CHAPTER 183). IF YOU DESIRE A HEARING, YOU MUST NOTIFY THE ADMINISTRATOR IN WRITING WITHIN TWENTY (20) DAYS OF THE DATE OF RECEIPT OF THIS NOTICE TO YOU. YOUR REQUEST MUST BE SENT TO THE DEPARTMENT OF CONSUMER AND BUSINESS SERVICES, WORKERS' COMPENSATION DIVISION, 350 WINTER STREET NE, SALEM, OREGON 97310. YOU WILL BE NOTIFIED OF THE TIME AND PLACE OF HEARING BY THE ADMINISTRATOR. IF YOU REQUEST A HEARING, YOU WILL BE GIVEN INFORMATION ON PROCEDURES, RIGHT OF REPRESENTATION, AND THE RIGHTS OF PARTIES RELATING TO THE CONDUCT OF THE HEARING. IF YOU FAIL TO REQUEST A HEARING WITHIN TWENTY (20) DAYS, THIS ORDER WILL BECOME FINAL BY OPERATION OF LAW AND THEREAFTER SHALL NOT BE SUBJECT TO REVIEW BY ANY AGENCY OR COURT."

Stat. Auth.: ORS 656.268, ORS 656.726 and 1995 OR Laws Chapter 332

Stats. Implemented: ORS 656.268, ORS 656.704, ORS 656.726 and 1995 OR Laws Chapter 332

Hist: Filed 12/10/90 as WCD Admin. Order 33-1990, eff. 12/26/90.

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Amended 2/14/96 as WCD Admin. Order 96-052, eff. 2/17/96.

Amended 12/22/97 as WCD Admin. Order 97-065, eff. 1/15/98.