

EXHIBIT "C"

BEFORE THE DIRECTOR OF THE
DEPARTMENT OF INSURANCE AND FINANCE
OF THE STATE OF OREGON

In the Matter of the Amendment)
of Rules Governing Claims) SUMMARY OF TESTIMONY
Administration (OAR Chapter 436,) AND AGENCY RESPONSES
Workers' Compensation Division,)
Division 60).)

This document relates to the Order of Adoption, WCD Administrative Order 4-1987, in the above referenced matter. It constitutes and contains a summary of the significant data, views, and arguments contained in the hearing record. It includes data submitted in accordance with the announcement that additional material could be submitted until November 13, 1987.

The purpose of this summary is to provide the Director with a record of the recommended agency conclusions about the major issues raised.

The amendment of the rules was announced in the Secretary of State's Administrative Rules Bulletin dated October 15, 1987. A public hearing was held on November 3, 1987. The Hearing was subsequently adjourned at 10:10 a.m. until November 13, 1987, to receive additional written testimony. During the hearing and intervening period interested persons presented written statements, arguments and recommendations in regard to the proposed rules. The major issues raised were:

TESTIMONY: The workers' compensation system should be changed so in accepted cases in which an insurer has issued a partial denial of compensability or of medical services, the insurer has the burden of proof.

RESPONSE: This proposal requires statutory amendment and cannot be changed by rule.

TESTIMONY: Mandatory penalties should be established for an insurer violation in complying with the literal discovery requirements of the present administrative rules.

RESPONSE: This proposal requires amendment to the Workers' Compensation Board administrative rules and cannot be accomplished by change to Claims Administration rules.

TESTIMONY: A structured fee schedule should be established for charges made by the medical profession to attorneys representing injured workers.

RESPONSE: This proposal requires either amendment to the Workers' Compensation Board or Medical Services administrative rules and cannot be accomplished by change to Claims Administration rules.

TESTIMONY: Section (1) of 60-005 should be amended to add to the definition of "Aggravation" the sentence: "The increase of symptoms alone is not grounds for an aggravation." This would be consistent with the 1986 Supreme Court case Smith v. SAIF, 302 Or 396 (1986), addressing the aggravation issues and pertinent criteria to meet such burden of establishing aggravation.

RESPONSE: Case law should be codified by statute rather than administrative rule. The section remains as written.

TESTIMONY: Section (2) of 60-005 should be amended to include in the definition of "Attending Physician" the language "and/or coordination" after the word "treatment" and before the word "of." The added language would clarify that the attending physician is responsible for necessary reporting and coordination of results from referring workers to specialty consultants.

RESPONSE: The current definition is congruous with the medical rules definition. The section remains as written.

TESTIMONY: Section (2) of 60-010 should be amended to clarify whether first-aid provided by a company nurse or doctor becomes medical services under this section and, therefore, requires the filing of a claim.

RESPONSE: The definition of "medical services" in the section describes such services as any medical treatment which is normally provided for an injury by a licensed individual, regardless of who provides it, or where it is provided. This means if it were not for a medical practitioner being available at the site of the injury, the worker would have to be sent to a doctor or hospital. The current definition is self-explanatory. The section remains as written.

TESTIMONY: Section (3) of 60-010 requiring a penalty against an employer who is delinquent in reporting claims to its insurer should have the penalty enforced directly by the Workers' Compensation Division to the employer.

RESPONSE: The rules already provide for penalty enforcement directly to the employer. The section remains as written.

TESTIMONY: Section (2) of 60-020 should be amended to the effect that the three-day waiting period would not apply where a worker misses fourteen consecutive days of time loss at any time in the first thirty days following the injury.

RESPONSE: The statute in 656.210(3) does not provide for a thirty day period in which to apply or not apply the three-day waiting period. The section remains as written.

TESTIMONY: Section (2) of 60-020 should be further defined to clarify that the three-day waiting period is three consecutive days away from work and not just three consecutive calendar days, regardless if worked.

RESPONSE: The statute in 656.210(3) describes the waiting period only as the first three calendar days after the worker leaves work and does not restrict it to days away from work. The section remains as written.

TESTIMONY: Section (3) of 60-020 should be further defined to include the phrase after the word "work" in the first sentence and before the word "for": "and the required leave is reasonable and necessary." The added language would deter workers who might abuse the system from scheduling necessary medical care or treatment during the early part of a shift just to receive time loss payments.

RESPONSE: To restrict the worker in scheduling medical care and treatment is not in keeping with the intent of the new law. Medical care and treatment is scheduled with the agreement of the doctor and available open appointments. The section remains as written.

TESTIMONY: Section (3) of 60-020 should be further defined to include the phrase after the word "injury" in the first sentence and before the word "is": "who has not been determined to be medically stationary." The added language makes it clear that the worker is only to be compensated for the time missed that is necessary for the medical examination and does not continue until the worker became medically stationary.

RESPONSE: The section is amended to reflect the concern and intent of the testimony.

TESTIMONY: Section (3) of 60-020 should be further defined to include the phrase in place of the word "a" in the first sentence and before the word "period": "any single." The added language makes it clear that the 4 hours absence is for each absence which exceeds 4 hours and not for a cumulative period of 4 hours.

RESPONSE: The section is amended to reflect the concern and intent of the testimony.

TESTIMONY: Section (3) of 60-020 should be further defined to include the phrase after the word "receive" in the first sentence and before the word "medical": "employer or insurer scheduled mandatory." The added language clarifies that the worker will only be paid if leaving work to attend a mandatory medical consultation or examination required by the employer or insurer.

RESPONSE: The statute in 656.210(4) does not limit the receipt of temporary disability to only employer or insurer scheduled medical consultation, examination or treatment. The proposal is not adopted.

TESTIMONY: Section (7) of 60-020 is unrealistic or unfair to the parties involved to suggest the insurer, employer and worker get together and work out a reasonable wage to determine temporary disability benefits in situations not covered by ORS 656.210 or this section. The parties should be able to come to the Director for resolution.

RESPONSE: The Director would not be able to confirm the intent at the time of hire. The resolution of such a dispute is by hearing. The section remains as written.

TESTIMONY: Section (7) of 60-020 should be further defined to include the sentence: "Dispute involving the setting of a reasonable wage will be resolved by an order of the Director." An administrative decision from the Director is the quickest way to resolve a continued dispute over a worker's wages.

RESPONSE: A dispute involving the setting of a reasonable wage is a matter concerning a claim and should be resolved by hearing in accordance with ORS 656.283. The section remains as written.

TESTIMONY: Subsection (7)(a) of 60-020 should be amended to figure the rate of compensation for workers "employed on call basis" on a period of 52 weeks rather than 26 weeks. This method would provide for averaging a seasonal worker's earnings to include periods where the worker would not be working even if healthy.

RESPONSE: The previous 52 weeks of employment may not reflect the current earning power of the worker. The subsection remains as written.

TESTIMONY: Subsection (7)(d) of 60-020 should be amended to base temporary disability received on what other workers of comparable pay scale and rank are making at time of injury and throughout the recovery period, rather than on an automatic five day work week for a worker employed through a union hall call board.

RESPONSE: The proposed information would be difficult for the insurer to obtain timely, thus making it additionally difficult for the insurer to pay temporary disability timely. A standard of employment is necessary for a union worker as they have no control over the type or length of employment when operating out of a union hall. The subsection remains as written.

TESTIMONY: Section (3) of 60-030 should be amended to include the phrase at the end of the sentence: "or is found eligible for and receives unemployment compensation." This change will make the rule consistent with the recent Oregon Court of Appeals decision Wells v. Pete Walker's Auto Body, 86 Or App 739 (1987).

RESPONSE: Case law should be codified by statute rather than administrative rule. The section remains as written.

TESTIMONY: Section (1) of 60-050 should not be amended as proposed as it relates to changing the language from "compensable injury" claim to "disabling" claim. It is felt that medical services for all claims should be paid by the insurer and that if the employer chooses to pay the amount of \$500 per claim for a nondisabling claim, that the employer reimburse the insurer.

RESPONSE: The section is amended to reflect the concern and intent of the testimony.

TESTIMONY: Section (2) of 60-050 should be amended to clarify what constitutes an industrial accident that requires eye glasses to be a compensable medical expense.

RESPONSE: The section is amended to reflect the concern and intent of the testimony by replacing the words "industrial accident" with "compensable injury." The definition of compensable injury is provided in ORS 656.005(7)(a).

TESTIMONY: Section (6) of 60-050 should reflect a policy and procedure on how the employer will pay the amount of \$500 per claim for a nondisabling claim while providing necessary information to the insurer, so medical services paid by the employer are not charged against the employer's experience rating.

RESPONSE: Temporary rule OAR 436-60-055 will be issued to reflect the concern and intent of the testimony.

TESTIMONY: Section (6) of 60-050 should be amended to include self-insured employers when permitting the employer to pay amounts not to exceed \$500 per claim for medical services for a nondisabling claim.

RESPONSE: Section (6) of 60-050 has been deleted and the subject is addressed in 60-055. The new rule reflects the concern and intent of the testimony.

TESTIMONY: Section (1) of 60-060 should not be amended to require approval by Compliance of permanent partial disability awards less than 64 degrees, when the aggregate total of all awards is greater than 64 degrees. The proposed change would increase paper work, add expense to the system and does not benefit the worker.

RESPONSE: The section is amended to reflect the concern and intent of the testimony.

TESTIMONY: Sections (1)-(13) of 60-060 should be eliminated as Workers' Compensation Division intervention in the method of lump sum payment of a permanent partial disability award is unnecessary and causes an aggravation to both the worker and the insurer.

RESPONSE: The statute in ORS 656.230(1) requires the Director's approval of a lump sum, where the award for permanent partial disability exceeds 64 degrees. The rule remains as written.

TESTIMONY: Section (8) of 60-060 should be amended to change from five working days to ten working days the time period in which the paying agent must pay an approved lump sum. The five working days is believed to be unnecessarily restrictive.

RESPONSE: The worker in many situations has an emergency need for the monies requested and an extended period of time for the insurer to make payment could cause a hardship on the worker. The section remains as written.

TESTIMONY: Section (1) of 60-070 should be amended to provide child care assistance to a single parent who cannot provide adequate care due to being disabled. Eligibility for child care should be determined by the Director.

RESPONSE: Child care assistance is available to the worker in case by case situations. To establish by rule a standard of eligibility for child care could result in being too restrictive in a specific situation. The section remains as written.

TESTIMONY: Subsection (2)(b) of 60-070 should be amended to not require reimbursement of transportation costs for travel by an injured worker to his employer's place of business to collect compensation benefits. Such a requirement discourages contact between the employer and injured worker.

RESPONSE: Employer supportive communication with a worker can occur separate from the payment of compensation checks by the mailing of the checks directly to the worker. The subsection remains as written.

TESTIMONY: Section (1) of 60-090 should be amended to change the word "examinations" to "examiners" as it relates to independent examinations allowed the insurer. It is felt that "examinations" is restrictive and that as many examinations as are reasonable and necessary should be allowed, but examinations must be limited to no more than three independent examiners.

RESPONSE: The statute in ORS 656.325(1) provides for no more than three "examinations" without authorization by the Director. The recommended change is not in keeping with the intent of the statute. The section remains as written.

TESTIMONY: Subsection (3)(f) of 60-090 should be amended to clarify what is "necessary" and "reasonable cost" of child care. A specific maximum fee similar to that for lodging, food or mileage reimbursement should be established. Suggested clarification is child care is not reimbursable during the worker's normal work shift or if the child is over 12 years of age.

RESPONSE: Subsection 60-070(2)(b) is amended to reflect the concern and intent of the testimony by making reference to payment of child care at the applicable rate prescribed by the Department of Human Resources, Children Services Division of the State of Oregon.

TESTIMONY: Subsection (3)(f) of 60-090 should be amended to identify what kind of things make up "other related services."

RESPONSE: ORS 656.325 describes "related services" but does not limit the definition of it. Related services is determined in case by case situations. To establish by rule a definition of related services could result in being too restrictive in a specific situation. The subsection remains as written.

TESTIMONY: Section (6) of 60-090 should be amended to require the worker's copy of the insurer's request to Compliance for consent to suspension of compensation be sent by registered mail to the worker to know if the worker receives the notification that they have 10 days to respond to the request.

RESPONSE: The section and similar sections in 60-100, 60-110 and 60-120 are amended to reflect the concern and intent of the testimony by making a similar requirement as prescribed by OAR 438-05-065 for the delivery of the notice of denial to the worker.

TESTIMONY: Add a new rule 60-115 to provide for a procedure to request for consent to suspend compensation for a worker who has been convicted of a crime and is incarcerated. This addition would recognize by rule the holding of the Oregon Supreme Court in Cutright v. Weyerhaeuser Company, 299 Or 290 (1985), that time loss payments are wage replacement and that individuals who are withdrawn from the labor force are ineligible.

RESPONSE: The termination of benefits for incarceration is not a suspension of benefits as described under ORS 656.325 which concerns only suspension of benefits for voluntary failure by the worker. The suspension of benefits during incarceration should be by legislative law change and not by rule. The new rule is not added.

TESTIMONY: Section (2) of 60-150 should be amended to place self-insured employers with third party administrators in the same category as guaranty contract insurers, so the 90 percent requirement for timely first payment of compensation applies only to self-administered self-insured employers. The argument at the original hearings on this requirement that self-insured employers do not have to deal with mailing of the first accident report to their insurers does not apply in a third party administered self-insured program. If the standard remains at 90 percent for a third party administered self-insured, the standard should apply only to the service company as a whole, not to each individual employer. This would accommodate situations where there are only a small number of claims for a self-insured employer.

RESPONSE: The reason for the difference of the 80 percent and 90 percent between the insurer and self-insured employer is that the self-insured employer has the ability to control reporting a claim. The insurer lacks the ability to control the five day period provided by law for the employer to report a claim. The section remains as written.

TESTIMONY: Section (3) of 60-180 should be amended to read: "With the consent of the Workers' Compensation Board, Own Motion claims are subject to the provisions of this rule." This amendment would expedite compensation to claimants who currently are denied compensation due to lack of authority by Compliance.

RESPONSE: The section is amended to reflect the concern and intent of the testimony.

TESTIMONY: Subsection (1)(b) of 60-200 should be amended to clarify what is meant by "Repeatedly." More than once can be interpreted to mean that it occurs more than once in any year or in an indefinite period of time.

RESPONSE: The subsection is amended to reflect the concern and intent of the testimony.

Having reviewed and considered all the data, views and arguments presented, I hereby submit this report as a summary of statements given and exhibits received, and recommend the adoption of the amendments to the rules to correspond with the above responses to the testimony.

Dated this 22 day of December, 1987.

Department of Insurance and Finance
Workers' Compensation Division



Fred Segrest, Deputy Administrator
Presiding Officer

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BEFORE THE DIRECTOR OF THE DEPARTMENT OF INSURANCE AND FINANCE OF THE STATE OF OREGON
DEC 18 3 23 PM '87
BARBARA
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In the Matter of the Amendment of Rules Governing Claims Administration (OAR Chapter 436, Workers' Compensation Division, Division 60).)
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ORDER OF ADOPTION

The Director of the Department of Insurance and Finance, pursuant to his general rule making authority under ORS 656.726(3) and in accordance with the procedure provided by ORS 183.335, amends OAR Chapter 436, Workers' Compensation Division, Division 60, Claims Administration.

On October 1, 1987, the Workers' Compensation Division filed Notice of Public Hearing with the Secretary of State to amend rules governing claims administration. The Statement of Need and Legal Authority and the Statement of Fiscal Impact were also filed with the Secretary of State.

Copies of the notice were mailed to interested persons in accordance with ORS 183.335(7) and OAR 436-01-000 and to those on the Division's distribution mailing list as their interest indicated. The notice was published in the October 15, 1987, Secretary of State's Administrative Rule Bulletin.

On November 3, 1987, the public hearing was held as announced. A summary of the written testimony and agency responses thereto is contained in Exhibit "C." This summary is on file and available for public inspection between the hours of 8 a.m. and 5 p.m., normal working days Monday through Friday in the Administrator's Office, Workers' Compensation Division, Room 200, Labor & Industries Bldg, Salem, Oregon 97310.

Having reviewed and considered the record of public hearing and being fully advised, I make the following findings:

- a. The applicable rule making procedures have been followed.
- b. The rules are within the Director's authority.
- c. The rules being adopted are a reasonable administrative interpretation of the statutes and are required to carry out statutory responsibilities.

REC'D W.C.D.

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LEGISLATIVE COUNSEL'S OFFICE

Administration

IT IS THEREFORE ORDERED THAT:

- (1) Rules Governing Claims Administration, OAR Chapter 436, Division 60, as set forth in Exhibit "A" attached hereto, certified a true copy and hereby made part of this order, is adopted effective January 1, 1988.
- (2) A certified true copy of the Order of Adoption and these rules, with Exhibit "B" consisting of the Citation of Statutory Authority, Statement of Need, Documents Relied on and Fiscal Impact Statement, attached hereto and hereby made a part of this order, be filed with the Secretary of State.
- (3) A copy of the rules and attached Exhibit "B" be filed with the Legislative Counsel pursuant to the provisions of ORS 183.715 within ten days after filing with the Secretary of State.

Dated this 18 day of December, 1987.

Department of Insurance and Finance


Theodore R. Kulongoski, Director

Distribution: A through N: P through V;
Plus Y through AA; CC; EE; LL

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EXHIBIT "A"

CHAPTER 436
DEPARTMENT OF INSURANCE AND FINANCE
WORKERS' COMPENSATION DIVISION
DIVISION 60, CLAIMS ADMINISTRATION

TABLE OF CONTENTS

436-60-001	Authority for Rules	1
436-60-002	Purpose	1
436-60-003	Applicability of Rules	1
436-60-005	Definitions	2
436-60-006	Administration of Rules	4
436-60-008	Administrative Review	4
436-60-010	Reporting Requirements	5
436-60-015	Notice to Worker's Attorney	6
436-60-020	Payment of Temporary Total Disability Compensation	6
436-60-030	Payment of Temporary Partial Disability Compensation	9
436-60-040	Payment of Permanent Partial Disability Compensation	10
436-60-050	Payment of Medical Services; Choice of Attending Physician	11
436-60-060	Lump Sum Payment of Permanent Partial Disability Awards	12
436-60-070	Reimbursement of Related Services Cost to a Worker	14
436-60-080	Consent to Suspension of Compensation or Reduction of Benefits Awarded the Worker	14
436-60-090	Request for Consent to Suspension of Compensation; Worker's Failure or Refusal to Submit to Medical Examination	16
436-60-100	Request for Consent to Suspension of Compensation; Worker's Failure to Participate in a Physical Rehabilitation Program	18
436-60-110	Request for Consent to Suspension of Compensation; Workers' Commission of Insanitary or Injurious Practices	20

436-60-120	Request for Consent to Suspension of Compensation; Worker's Refusal to Submit to Medical or Surgical Treatment	23
436-60-130	Petition for Reduction of Benefits; Worker's Failure to Follow Medical Advice or Participate in or Complete Physical Restoration or Vocational Rehabilitation Programs or Commission of Insanitary or Injurious Practices	25
436-60-140	Acceptance or Denial of a Claim	26
436-60-150	Timely Payment of Compensation	27
436-60-160	Use of Sight Draft to Pay Compensation Prohibited	29
436-60-170	Recovery of Overpayment of Benefits	29
436-60-180	Designation and Responsibility of a Paying Agent	30
436-60-190	Monetary Adjustments Among Parties and Department of Insurance and Finance	32
436-60-200	Assessment of Civil Penalties	33
436-60-210	Issuance/Service of Penalty Orders	34

AUTHORITY FOR RULES

436-60-001 These rules are promulgated under the Director's authority contained in ORS 656.210(2), 656.264, 656.265(6), 656.325, 656.331 and 656.726(3).

Hist: Filed 12/19/75 as WCB Admin. Order 18-1975, eff. 1/1/76
Amended 4/27/78 as WCD Admin. Order 6-1978, eff. 4/27/78
Amended 1/11/80 as WCD Admin. Order 1-1980, eff. 1/11/80
Amended 12/29/83 as WCD Admin. Order 8-1983, eff. 1/1/84
Renumbered from 436-54-001, May 1, 1985
Amended 12/12/85 as WCD Admin. Order 8-1985, eff. 1/1/86

PURPOSE

436-60-002 It is the purpose of the Director that under the provisions of ORS 656.726(3) rules be established to allow insurers to uniformly process claims. One of the general charges to the Director under the Workers' Compensation Law is ". . . regulation and enforcement of . . . ORS 656.001 to 656.794." To meet that responsibility the Director has delegated to Compliance the responsibility of ensuring the requirements of the statutes, rules and bulletins of the Department are complied with as they relate to claims processing. To that end, when it comes to the attention of Compliance that an insurer is not processing a claim in accordance with the requirements of the law, Compliance will so notify the insurer and request immediate appropriate action. If the appropriate action is not taken by the insurer in accordance with the law the insurer will be subject to civil penalty under ORS 656.745.

Hist: Filed 4/27/78 as WCD Admin. Order 6-1978, eff. 4/27/78
Amended 1/11/80 as WCD Admin. Order 1-1980, eff. 1/11/80
Amended 12/29/83 as WCD Admin. Order 8-1983, eff. 1/1/84
Renumbered from 436-54-008, May 1, 1985
Amended 12/12/85 as WCD Admin. Order 8-1985, eff. 1/1/86
Amended 12/18/87 as WCD Admin. Order 4-1987, eff. 1/1/88

APPLICABILITY OF RULES

436-60-003 These rules are effective January 1, 1988, to carry out the provisions of:

- (1) ORS 656.210 - Temporary total disability
- (2) ORS 656.212 - Temporary partial disability
- (3) ORS 656.230 - Lump sum payments with Department approval
- (4) ORS 656.245 - Medical services to be provided; choice of doctor
- (5) ORS 656.262 - Responsibility for processing and payment of compensation; sight drafts; acceptance and denial of claim; reporting claims; penalties for payment delays

- (6) ORS 656.264 - Compensable injury, claim and other reports
 - (7) ORS 656.265 - Notice of accident from worker
 - (8) ORS 656.268 - Insurer claim closures
 - (9) ORS 656.307 - Determination of issues regarding responsibility for compensation payment
 - (10) ORS 656.325 - Required medical examination; suspension of compensation; injurious practices; claimant's duty to reduce disability; reduction of benefits for failure to participate in rehabilitation
 - (11) ORS 656.331 - Notice to worker's attorney
 - (12) ORS 656.726(3) - Department powers and duties generally
- Hist: Filed 4/27/78 as WCD Admin. Order 6-1978, eff. 4/27/78
Amended 1/11/80 as WCD Admin. Order 1-1980, eff. 1/11/80
Amended 12/23/81 as WCD Admin. Order 6-1981, eff. 1/1/82
Amended 12/29/83 as WCD Admin. Order 8-1983, eff. 1/1/84
Amended 4/4/84 as WCD Admin. Order 3-1984, eff. 4/4/84
Renumbered from 436-54-003, May 1, 1985
Amended 12/12/85 as WCD Admin. Order 8-1985, eff. 1/1/86
Amended 12/18/87 as WCD Admin. Order 4-1987, eff. 1/1/88

DEFINITIONS

436-60-005 For the purpose of these rules unless the context requires otherwise:

(1) "Aggravation" means the worsened condition of an injured worker which is a medically verified increase in seriousness or severity of a condition arising from an industrial injury to the worker since the last award or arrangement of compensation for that industrial injury.

(2) "Attending Physician" means a doctor or physician who accepts the primary responsibility for the treatment of a worker's compensable injury.

(3) "Board" means the Workers' Compensation Board of the Department of Insurance and Finance.

(4) "Claim" means a written request for compensation from a subject worker or someone on the worker's behalf, or any compensable injury of which a subject employer has notice or knowledge.

(5) "Compliance" means the Compliance Section of the Workers' Compensation Division of the Department of Insurance and Finance.

(6) "Department" means the Department of Insurance and Finance.

(7) "Determination" means examination of the worker's claim for compensation by Evaluation.

(8) "Director" means the Director of the Department of Insurance and Finance or the Director's delegate for the matter.

(9) "Division" means the Workers' Compensation Division of the Department of Insurance and Finance, consisting of the Compliance Section, Evaluation Section and Rehabilitation Review Section.

(10) "Employment on call" means sporadic, unscheduled employment on call by an employer with no right of reprisal if employe unavailable.

(11) "Employment through union hall" means workers who report to union halls for job placement.

(12) "Evaluation" means the Evaluation Section of the Workers' Compensation Division of the Department of Insurance and Finance.

(13) "Health insurance," as defined under ORS 731.162, means insurance of humans against bodily injury, disablement or death by accident or accidental means, or the expense thereof, or against disablement or expense resulting from sickness or childbirth, or against expense incurred in prevention of sickness, in dental care or optometrical service, and every insurance appertaining thereto. "Health insurance" does not include workers' compensation coverage.

(14) "Insurer" means the State Accident Insurance Fund Corporation, an insurer authorized under ORS Chapter 731 to transact workers' compensation insurance in this state or an employer or employer group who has been certified under ORS 656.430 that the employer or employer group meets the qualifications of a self-insured employer set out by ORS 656.407.

(15) "Loss of earning power" means the difference between wage earnings of the worker from the employment at the time of and giving rise to the injury and the wage earnings available from any kind of work approved by the attending physician prior to claim determination which is available to the injured worker, whether or not the work is accepted or performed.

(16) "Lump sum" means the payment of all or any part of a permanent partial disability award in one payment.

(17) "Medical Director" means the Medical Director in the office of the Director of the Department of Insurance and Finance.

(18) "Party" means a claimant for compensation, the employer of the injured worker at the time of injury and the insurer, if any, of such employer.

(19) "Paying Agent" means the insurer responsible for paying compensation for a compensable injury.

(20) "Physical rehabilitation program" means any disability prevention services which include physical restoration provided a worker.

(21) "Process claims" means the receipt, review and payment of compensation of claims of workers.

Hist: Filed 4/27/78 as WCD Admin. Order 6-1978, eff. 4/27/78
Amended 1/11/80 as WCD Admin. Order 1-1980, eff. 1/11/80
Amended 12/23/81 as WCD Admin. Order 6-1981, eff. 1/1/82
Amended 12/29/83 as WCD Admin. Order 8-1983, eff. 1/1/84
Renumbered from 436-54-005, May 1, 1985
Amended 12/12/85 as WCD Admin. Order 8-1985, eff. 1/1/86
Amended 12/18/87 as WCD Admin. Order 4-1987, eff. 1/1/88

ADMINISTRATION OF RULES

436-60-006 Any orders issued by the Division in carrying out the Director's authority to enforce ORS Chapter 656 and the rules adopted pursuant thereto, are considered orders of the Director.

Hist: Filed 4/27/78 as WCD Admin. Order 6-1978, eff. 4/27/78
Amended 1/11/80 as WCD Admin. Order 1-1980, eff. 1/11/80
Amended 12/29/83 as WCD Admin. Order 8-1983, eff. 1/1/84
Renumbered from 436-54-010, May 1, 1985
Amended 12/12/85 as WCD Admin. Order 8-1985, eff. 1/1/86
Amended 12/18/87 as WCD Admin. Order 4-1987, eff. 1/1/88

ADMINISTRATIVE REVIEW

436-60-008 (1) Any party aggrieved by an action taken pursuant to these rules involving any matter concerning a claim may request a hearing by the Hearings Division of the Workers' Compensation Board in accordance with ORS Chapter 656 and the Board's Rules of Practice and Procedure for Contested Cases under the Workers' Compensation Act.

(2) Any party aggrieved by an action taken pursuant to these rules involving all matters other than those concerning a claim may request a hearing of the Director.

(a) The Director shall forward the request for a hearing to the Department of Justice with pertinent records in the matter as requested.

(b) The Department of Justice shall forward the request and other pertinent information to the Hearings Division.

(c) Notwithstanding ORS 183.315(1), the issuance of orders under these rules, the conduct of hearings and the judicial review thereof by the Court of Appeals shall be as provided in ORS 183.415 through ORS 183.495 except:

(A) the Board may promulgate rules for the conduct of the hearings under these rules;

(B) the order of the hearing referee shall be deemed to be a final order of the Director; and

(C) the Director shall have the same right to a judicial review of the order of the hearing referee as any person who is adversely affected or aggrieved by such final order.

Hist: File 4/27/78 as WCD Admin. Order 6-19-78, eff. 4/27/78
Amended 1/11/80 as WCD Admin. Order 1-1980, eff. 1/11/80
Amended 12/29/83 as WCD Admin. Order 8-1983, eff. 1/1/84
Renumbered from 436-54-998, May 1, 1985
Amended 12/12/85 as WCD Admin. Order 8-1985, eff. 1/1/86

REPORTING REQUIREMENTS

436-60-010 (1) A subject employer shall accept notice of a claim for workers' compensation benefits from any injured worker or their representative. Employers, except self-insured employers processing their own claims, shall immediately and not later than five days after notice or knowledge of any claim or accident which may result in a compensable injury claim, report the same to their insurer.

(2) If a worker is injured and requires only first aid without medical services and is otherwise not entitled to compensation, no notice need be given the insurer where the employer maintains records of the date, worker and nature of injury treated for at least one year, which records shall be open to inspection by the Director or any party or its representative. For the purpose of this section, "medical services" means any medical treatment which is normally provided for an injury by a licensed individual, regardless of who provides it, or where it is provided.

(3) An employer who is delinquent in reporting claims to its insurer in excess of 10 percent of their total claims reported during any quarter may receive a penalty assessed by the Director.

(4) An employer who intentionally or repeatedly makes payment of compensation in lieu of reporting to its insurer any claim or accident which may result in a compensable injury claim may receive a penalty assessed by the Director.

(5) The insurer shall receive, process and file a claim in compliance with ORS Chapter 656 to include reports as required in Chapter 656, WCD Administrative Orders and WCD Bulletins. A "First Medical Report" Form 827, signed by the worker, is considered written notice of an accident which may involve a compensable injury in accordance with ORS 656.265. As such, the signed Form 827 shall start the claim process the same as the Form 801, but shall not relieve the worker or employer of the responsibility of filing Form 801.

(6) Any insurer who is delinquent in reporting or who submits the Forms 801, 1502, 1503 or 1644 with a late or error ratio of 10 percent of the volume of each respective form during any quarter may receive a penalty assessed by the Director.

Hist: Filed 1/11/80 as WCD Admin. Order 1-1980, eff. 1/11/80
Amended 12/23/81 as WCD Admin. Order 6-1981, eff. 1/1/82
Amended 12/29/83 as WCD Admin. Order 8-1983, eff. 1/1/84
Renumbered from 436-54-100, May 1, 1985
Amended 12/12/85 as WCD Admin. Order 8-1985, eff. 1/1/86
Amended 12/18/87 as WCD Admin. Order 4-1987, eff. 1/1/88

NOTICE TO WORKER'S ATTORNEY

436-60-015 (1) When an injured worker is represented by an attorney and the attorney has given written notice of such representation:

(a) The Director or insurer shall not request the worker to submit to an independent medical examination without giving prior or simultaneous written notice to the worker's attorney.

(b) The insurer shall not request suspension of compensation pursuant to ORS 656.325 without giving prior or simultaneous written notice to the worker's attorney.

(c) An insurer shall not contact the worker without giving prior or simultaneous written notice to the worker's attorney if the contact affects the denial, reduction or termination of the worker's benefits.

(2) An insurer who intentionally or repeatedly fails to give prior or simultaneous written notice to the worker's attorney as required by section (1) may receive a penalty assessed by the Director.

Hist: Filed 12/12/85 as WCD Admin. Order 8-1985, eff. 1/1/86

PAYMENT OF TEMPORARY TOTAL DISABILITY COMPENSATION

436-60-020 (1) Payment of compensation under ORS 656.262(4) may be made by the subject employer if the employer so chooses. The making of such payments does not constitute a waiver or transfer of the insurer's duty to determine entitlement to benefits or responsibility to ensure timely benefit payments. The employer shall provide its insurer with adequate payment documentation, as the insurer may require, to meet these responsibilities.

(2) No compensation is due for temporary total disability suffered during the first three calendar days after the worker leaves work as a result of a compensable injury, unless the total disability is continuous for a period of 14 days or the worker is an inpatient in a hospital within the first period of time loss. The three day waiting period is three consecutive calendar days beginning with the day the worker first loses time from work as a result of the compensable injury. If the worker leaves work but returns and completes the work shift, that day shall not be considered the first day of the three day waiting period. If the worker leaves work and does not complete the work shift, that day shall be considered the first day of the three day waiting period even though the worker may return to the next scheduled work shift. The three day waiting period applies to temporary partial disability pursuant to ORS 656.212 the same as it does for temporary total disability.

(3) Until such time as the worker is determined to be medically stationary, when a worker with an accepted disabling compensable injury is required to leave work for any single period of four hours or more to receive medical consultation, examination or treatment with regard to the compensable injury, the worker shall receive temporary disability benefits calculated pursuant to ORS 656.212 for the period during which the worker is absent.

However, such benefits are not payable if wages are paid for the period of absence by the employer.

(4) When concurrent temporary disability is due the worker as a result of two or more separate claims, the insurers may petition Compliance to make a pro rata distribution of compensation due under ORS 656.210. The insurers shall not unilaterally prorate temporary disability without the approval of Compliance. Compliance may order one of the insurers to pay the entire amount of temporary disability due or it may make a pro rata distribution between two or more of the insurers.

(5) The rate of compensation for regularly employed workers shall be computed as outlined in ORS 656.210. Monthly wages shall be divided by 4.35 to determine weekly wages. Continued payment of wages by the employer shall not be made in lieu of statutory temporary total disability due. The employer, however, is not precluded from supplementing the amount of temporary total disability paid the worker. Any workers' compensation benefits shall be identified separate from other moneys paid by the employer and shall not have usual payroll deductions withheld from such benefits.

(6) The rate of compensation for workers employed with minimal earnings and entitled to the lesser amount of 90 percent of wages a week or the amount of \$50.00 shall be computed as follows: Use 90 percent of weekly wages when worker's wages are \$55.56 or less per week; Use \$50.00 when worker's weekly wage falls between \$55.56 and \$75.00 per week; Use 66 2/3 percent of weekly wages when the worker's wages are \$75.00 or more per week.

(7) The rate of compensation for workers employed with unscheduled, irregular or no earnings shall be computed on the wages determined by this section. Situations not covered by ORS 656.210 or this section shall be resolved by the insurer contacting the employer and worker to determine a reasonable wage to coincide with the objectives of the Workers' Compensation Law.

(a) Employed on call basis: Use average weekly earnings for past 26 weeks, if available, unless periods of extended gaps exist, then use no less than last 4 weeks of employment to arrive at average. For workers employed less than 4 weeks, or where extended gaps exist within the 4 weeks, use intent at time of hire as confirmed by employer and worker.

(b) Employed Piecework: Use average as in subsection (a).

(c) Employed varying hours, shifts or wages: Use average as in subsection (a).

(d) Employed through union hall call board: Compute as 5 day worker regardless of number of days actually worked per week.

(e) Employed salary plus considerations (rent, utilities, food, etc.): Use only salary if considerations continue; use salary plus reasonable value of considerations if lost.

(f) Employed two jobs, two employers: Use only wage of job on which injury occurred if worker unable to work either job. If able to return to job where injury occurred, no benefit is due. If able to return to the job other than the one where injury occurred, temporary partial disability is due based on the combined earning power of both jobs.

(g) Employed where tips are a part of earnings: Use regular wages actually received, plus amount of tips required to be reported by the employer pursuant to section 6053 of the Internal Revenue Code of 1954, as amended, or the amount of actual tips reported by the worker, whichever amount is greater. Tips include tips the worker receives directly from customers, tips from charge customers that are paid to the worker by the employer, and the worker's share of any tips the worker receives under a tip-splitting arrangement.

(h) Employed 1 or 2 days per week: Use daily wage times 3 to arrive at weekly wage (ORS 656.210).

(i) Employed with overtime: Overtime shall be considered only when worked on a regular basis. Overtime earnings shall be considered at the overtime rate rather than straight time. Example: If one day of overtime per month for a normally 40 hour a week worker, use 40 hours at regular wage and 2 hours at overtime wage; etc., to compute the weekly rate. If overtime varies in hours worked per day or week, use average as in subsection (a). One-half day or more will be considered a full day when determining days worked per week.

(j) Employed with incentive pay: Incentive pay provided by contract of employment shall be considered only when regularly earned. If incentive pay earnings vary, use average as in subsection (a).

(k) Employed with no wage earnings: Volunteer workers, city and county jail inmates, etc., when covered, shall have their benefits computed on the same assumed wage as premium is based.

(l) Employed commission only; commission plus wages: Use average commission earnings for past 26 weeks, if available. For workers without 26 weeks of earnings use the assumed wage on which premium is based. Any regular wage in addition to commission shall be included in the wage.

(m) Sole proprietors, partners and officers of corporation: Use assumed wage on which premium is based.

(n) School teachers or workers paid in like manner: Use annual salary divided by 52 weeks to arrive at weekly wage. Statutory temporary disability benefits shall extend over the calendar year.

(8) When payable, compensation for the initial work day lost shall be paid for 1/2 day if the worker leaves the job during the first half of the shift and no compensation for the initial work day lost if the worker leaves the job during the second half of the shift.

(9) When a working shift extends into another calendar day, the date of injury shall be the date used for payroll purposes by the employer.

Hist: Filed 9/21/70 as WCB Admin. Order 12-1970
Amended 1/11/80 as WCD Admin. Order 1-1980, eff. 1/11/80
Amended 12/23/81 as WCD Admin. Order 6-1981, eff. 1/1/82
Amended 12/29/83 as WCD Admin. Order 8-1983, eff. 1/1/84
Renumbered from 436-54-212, May 1, 1985
Amended 12/12/85 as WCD Admin. Order 8-1985, eff. 1/1/86
Amended 12/18/87 as WCD Admin. Order 4-1987, eff. 1/1/88

PAYMENT OF TEMPORARY PARTIAL DISABILITY COMPENSATION

436-60-030 (1) The rate of temporary partial disability compensation due a worker shall be determined by:

(a) subtracting the post-injury wage earnings available from any kind of work; from

(b) the wage earnings from the employment at the time of, and giving rise to, the injury; then

(c) dividing the difference by the wage earnings in subsection (b) to arrive at the percentage of loss of earning power; then

(d) multiplying the current temporary total disability compensation rate by the percentage of loss of earning power.

(2) If the post-injury wage earnings are equal to or greater than the wage earnings at the time of injury, no temporary disability compensation is due.

(3) An insurer shall cease paying temporary total disability compensation and commence making payment of such temporary partial disability compensation as is due from the date an injured worker accepts and commences any kind of wage earning employment prior to claim determination.

(4) Temporary partial disability compensation payable pursuant to section (3) shall continue to be paid until:

(a) the attending physician verifies that the worker cannot continue working and is again temporarily totally disabled;

(b) the compensation is terminated by order of the Department or by claim closure by the insurer pursuant to ORS 656.268; or

(c) the compensation has been paid for two years.

(5) An insurer shall cease paying temporary total disability compensation and start making payment of such temporary partial disability compensation as would be due in section (1) when an injured worker refuses wage earning employment prior to claim determination under the following conditions:

(a) the attending physician has been notified by the employer or insurer of the specific duties to be performed by the injured worker and the physical requirements thereof;

(b) the attending physician agrees that the offered employment appears to be within the worker's capabilities; and

(c) the employer has provided the injured worker with a written offer of the employment which states the beginning time, date and place; the duration of the job, if known; the wage rate payable; an accurate description of the job duties and that the attending physician has said the offered employment appears to be within the worker's capabilities.

(6) Temporary partial disability compensation payable pursuant to section (5) shall continue to be paid until:

(a) the attending physician verifies that the worker's condition is such that he could no longer perform such work and is again temporarily totally disabled;

(b) the duration of the offered job has expired or that the offer of such employment is withdrawn. The employer discharging the worker because of violation of normal employment standards shall not be considered a withdrawal of offered employment;

(c) the compensation is terminated by order of the Department or by claim closure of the insurer pursuant to ORS 656.268; or

(d) the compensation has been paid for two years.

(7) An insurer shall provide a written explanation to the injured worker, and the worker's attorney if represented, of the reasons for changes in the compensation rate and the method of computation whenever temporary total disability compensation is terminated and temporary partial disability compensation commences, and vice versa. A copy of the letter to the worker shall be sent to Compliance in cases where the worker has refused wage earning employment.

Hist: Filed 4/27/78 as WCD Admin. Order 6-1978, eff. 4/27/80
Amended 1/11/80 as WCD Admin Order 1-1980, eff. 1/11/80
Amended 12/23/81 as WCD Admin. Order 6-1981, eff. 1/1/82
Amended 12/29/83 as WCD Admin. Order 8-1983, eff. 1/1/84
Renumbered from 436-54-222, May 1, 1985
Amended 12/12/85 as WCD Admin. Order 8-1985, eff. 1/1/86
Amended 12/18/87 as WCD Admin. Order 4-1987, eff. 1/1/88

PAYMENT OF PERMANENT PARTIAL DISABILITY COMPENSATION

436-60-040 (1) The worker may receive both permanent partial disability and temporary total disability at the same time. When a claim is reopened as a result of an aggravation of the worker's condition and temporary total disability is due, any permanent partial disability benefits due shall continue to be paid concurrently with temporary total disability benefits.

(2) When training commences in accordance with OAR 436-120 after the issuance of a determination order, Opinion and Order of a Referee, Order on

Review, or Mandate of the Court of Appeals, the insurer shall suspend any award payments due under the order or mandate and pay time loss.

(3) Upon completion or ending of the training, unless the worker then is not medically stationary, the insurer shall stop temporary disability compensation payments and resume any suspended award payments. If no award payment remains due, temporary disability shall continue pending a subsequent determination order by Evaluation, unless the worker has returned to regular employment. If the worker has returned to work, the insurer may reevaluate and close the claim without the issuance of a determination order by Evaluation.

Hist: Filed 12/23/81 as WCD Admin. Order 6-1981, eff. 1/1/82
Amended 12/29/83 as WCD Admin. Order 8-1983, eff. 1/1/84
Renumbered from 436-54-232, May 1, 1985
Amended 12/12/85 as WCD Admin. Order 8-1985, eff. 1/1/86
Amended 12/18/87 as WCD Admin. Order 4-1987, eff. 1/1/88

PAYMENT OF MEDICAL SERVICES; CHOICE OF ATTENDING PHYSICIAN

436-60-050 (1) Except as provided by OAR 436-60-055, only the insurer shall pay for medical services relating to a compensable injury claim. Such services include, but are not limited to, medical, surgical, hospital, nursing, ambulances, and other related services, and drugs, medicine, crutches and prosthetic appliances, braces and supports and where necessary, physical restorative services.

(2) For the purpose of this rule, a prosthetic appliance is an artificial substitute for a missing part or any device by which performance of a natural function is aided or augmented, including, but not limited to, hearing aids or eye glasses. If such a prosthetic appliance is damaged when in use at the time of a compensable injury the cost is a compensable medical expense, regardless of whether the worker actually received a physical injury at the time of the compensable injury.

(3) Any claim for medical services referred to under ORS 656.245 or this rule shall be submitted to the insurer even after aggravation rights under ORS 656.273 have expired. If the claim for medical services is denied, the worker may submit a request for hearing pursuant to ORS 656.283.

(4) The worker may choose an attending physician within the state of Oregon. Reimbursement to the worker of transportation costs to visit the attending physician, however, may be limited to within a city, or metropolitan area, or the distance to the nearest city or metropolitan area, from where the worker resides and where a physician providing like services is available. A worker who relocates within the state of Oregon may continue treating with the attending physician and be reimbursed transportation costs accordingly. If an insurer chooses to limit reimbursement to the nearest available city, or metropolitan area, a written explanation shall be provided the worker along with a list of physicians who provide the like services within an acceptable distance of the worker. The worker shall be made aware of the fact treatment may continue with any attending physician within the state of Oregon of the

worker's choice, but the reimbursement of transportation costs will be limited as described.

(5) When the worker chooses an attending physician outside the state of Oregon, the insurer may object to the worker's choice and select the attending physician. Payment for treatment or services rendered to the worker after the insurer has objected to the worker's choice of attending physician may be rejected by the insurer.

Hist: Filed 12/23/81 as WCD Admin. Order 6-1981, eff. 1/1/82
Amended 12/29/83 as WCD Admin. Order 8-1983, eff. 1/1/84
Renumbered from 436-54-245, May 1, 1985
Amended 12/12/85 as WCD Admin. Order 8-1985, eff. 1/1/86
Amended 12/18/87 as WCD Admin. Order 4-1987, eff. 1/1/88

LUMP SUM PAYMENT OF PERMANENT PARTIAL DISABILITY AWARDS

436-60-060 (1) A lump sum payment of any award must be approved by Compliance when an award for permanent partial disability exceeds 64 degrees. Such required approval extends to situations where the value of the award, through periodic payments or offset, is reduced to below the 64 degree value. Subsequent awards below the 64 degree value shall be paid by the insurer in the same manner as provided by ORS 656.230(2). Any lump sum payment of a permanent partial disability award ordered as a result of litigation does not require Compliance approval.

(2) For injuries occurring prior to August 9, 1983, Compliance hereby authorizes the insurer, in its discretion, to make a lump sum payment of a permanent partial disability award not in excess of 64 degrees provided the worker is not asked to waive any appeal rights. For injuries occurring on or after August 9, 1983, and the award does not exceed 64 degrees, the insurer shall pay all of the award to the worker in a lump sum.

(3) In cases where the final payment would be less than the amount computed in accordance with ORS 656.216(1), the insurer may include the lesser amount with the last full monthly payment of the award to the worker without Compliance approval.

(4) A worker who has been awarded a permanent partial disability award in excess of 64 degrees may apply to Compliance, through the insurer, for an order directing the paying agent to pay all or part of the unpaid award in a lump sum. Any lump sum award will be subject to the law in force at the time of injury.

(5) The application shall include but not be limited to:

(a) a description of the award amount, amount of the monthly payments being paid, payments already paid, balance remaining and amount of award requested;

(b) original signatures of both the worker and the insurer; and

(c) in prominent or bold-face type the paragraph:

"I UNDERSTAND THAT BY APPLYING FOR AND ACCEPTING A LUMP SUM PAYMENT OF ALL OR ANY PART OF MY PERMANENT PARTIAL DISABILITY AWARD, I WAIVE THE RIGHT TO APPEAL THE ADEQUACY OF THE AWARD."

(6) Compliance, in considering an application will not approve a lump sum payment when:

(a) the worker is engaged in a vocational assistance training program;

(b) the worker is receiving vocational assistance or is temporarily withdrawn from a training program; or

(c) the worker is engaged in litigation affecting the worker's permanent partial disability award.

(7) Compliance shall approve or deny an application for lump sum payment of an award within 30 days after receipt of the application, unless additional information is needed to make a decision. Compliance may approve an application to pay all or part of the award, as requested, or it may approve a lump sum payment of less than requested, or it may deny an application.

(8) If Compliance approves an application, as submitted or as revised, it shall order the paying agency to pay the award in a lump sum in the amount approved within 5 working days after receipt of the order. Copies of the order and application approving or denying the application shall be sent to the paying agent and the applicant.

(9) If the application is denied in whole or in part by Compliance, the worker shall be informed that within 15 days of the date of the order, the Director may be petitioned to reconsider the application.

(10) The Director shall, within 20 days after receipt of the petition, examine the application and such further evidence filed and enter an order. Copies of the order shall be sent to the paying agent, applicant and Compliance. Granting or denying a lump sum is at the sole discretion of the Director. Any such order issued by the Director is not appealable.

(11) If a lump sum payment is approved for part of an award, the lump sum payment shall be in addition to the regularly scheduled monthly payment. The remaining balance shall be paid pursuant to ORS 656.216.

(12) Denial or approval of an application does not prevent another application by the worker for a lump sum payment of all or part of any remainder of the award, provided additional justification is submitted.

(13) Nothing in this rule applies to any lump sum payment included in a compromise settlement of a case that is pending before the Hearings Division of the Board.

Hist: Filed 6/23/66 as WCB Admin. Order 6-1966
Amended 2/13/74 as WCB Admin. Order 5-1974, eff. 3/11/74
Amended 1/11/80 as WCD Admin. Order 1-1980, eff. 1/11/80
Amended 12/23/81 as WCD Admin. Order 6-1981, eff. 1/1/82

Amended 12/29/83 as WCD Admin. Order 8-1983, eff. 1/1/84
Renumbered from 436-54-250, May 1, 1985
Amended 12/12/85 as WCD Admin. Order 8-1985, eff. 1/1/86
Amended 12/18/87 as WCD Admin. Order 4-1987, eff. 1/1/88

REIMBURSEMENT OF RELATED SERVICES COST TO A WORKER

436-60-070 (1) The worker shall be notified at the time of claim acceptance that travel, prescriptions and other compensable injury related services paid by the worker will be reimbursed by the insurer upon request.

(2) For the purpose of this rule:

(a) The actual reasonable cost to a worker of related services resulting from a compensable injury shall be reimbursed within 60 days of the date of receipt by the insurer of a written request. The request shall be accompanied by sales slips, receipts or other evidence necessary to support the request.

(b) Meals, lodging, public transportation or use of a private vehicle required to seek medical services or collect compensation benefits when reimbursed at the then applicable rate of reimbursement to State of Oregon classified employes shall be deemed in compliance with this section. Child care benefits when reimbursed at the then applicable rate as prescribed by the Department of Human Resources, Children Services Division of the State of Oregon shall be deemed in compliance with this section. Reimbursement in excess of these rates will be allowed in those cases where special transportation, lodging or child care is necessary and required.

(3) Requests for reimbursement of services not claim-related shall be returned to the injured worker within 60 days of the date of receipt by the insurer with an explanation of the reason for nonpayment.

Hist: Filed 10/23/69 as WCB Admin. Order 6-1969, eff. 10/29/69
Amended 1/11/80 as WCD Admin. Order 1-1980, eff. 1/11/80
Amended 12/23/81 as WCD Admin. Order 6-1981, eff. 1/1/82
Amended 12/29/83 as WCD Admin. Order 8-1983, eff. 1/1/84
Renumbered from 436-54-270, May 1, 1985
Amended 12/12/85 as WCD Admin. Order 8-1985, eff. 1/1/86
Amended 12/18/87 as WCD Admin. Order 4-1987, eff. 1/1/88

CONSENT TO SUSPENSION OF COMPENSATION OR REDUCTION OF BENEFITS AWARDED THE WORKER

436-60-080 (1) Compliance is responsible for issuing an order of consent to the suspension of compensation by an insurer under the following conditions:

(a) An order shall be issued if the worker, when requested by the Director or insurer, fails or refuses to submit to medical examination, or obstructs the same, at a time and from time to time at a place reasonably convenient for the worker. The compensation under the order shall be suspended until the examination has taken place. No compensation shall be due or paid during such period.

(b) An order shall be issued for any period of time during which a worker fails or refuses to participate in a physical rehabilitation program. No compensation shall be due or paid during such period.

(c) An order shall be issued for any period of time during which a worker commits any insanitary or injurious practice which tends to either imperil or retard recovery. No compensation shall be due or paid during such period.

(d) An order shall be issued for any period of time during which a worker refuses to submit to such medical or surgical treatment as is reasonably essential to promote recovery. No compensation shall be due or paid during such period.

(2) The worker shall be provided the opportunity to dispute the matter of suspension of compensation prior to the issuance of an order by Compliance.

(3) Compliance may modify or set aside any order of consent to the suspension of compensation authorized before or after a request for hearing is filed.

(4) Compliance has the authority to order payment of compensation, previously authorized suspended, in cases where incorrect information was provided at the time suspension occurred.

(5) Compliance shall notify all interested parties of any order authorizing suspension, any modification of such order or the setting aside of such order.

(6) Compliance may modify the period of suspension of compensation or deny a request for suspension of compensation because of an improper request.

(7) Continued payment of compensation to a worker, when an order of consent has been issued, shall not constitute failure to comply with this section on the part of the insurer, however, such continued payment shall not be recovered at a later date as an overpayment.

(8) Evaluation may reduce, upon petition by the employer of the injured worker, the insurer or upon instructions by the Director, any benefits awarded the worker pursuant to ORS 656.268 when the worker has, without a valid reason, failed to follow medical advice of the attending physician or has failed to participate in or complete physical rehabilitation or vocational assistance programs prescribed for the worker pursuant to ORS Chapter 656 and WCD Administrative Rules. The benefits may be reduced by the amount the disability has been increased by the worker's failure to follow medical advice of the attending physician or to participate in or complete physical rehabilitation or vocational assistance programs.

Hist: Filed 12/11/70 as WCB Admin. Order 16-1970
Amended 4/27/78 as WCD Admin. Order 6-1978, eff. 4/27/78
Amended 1/11/80 as WCD Admin. Order 1-1980, eff. 1/11/80
Amended 12/13/81 as WCD Admin. Order 6-1981, eff. 1/1/82
Amended 12/29/83 as WCD Admin. Order 8-1983, eff. 1/1/84

Renumbered from 436-54-280, May 1, 1985
Amended 12/12/85 as WCD Admin. Order 8-1985, eff. 1/1/86
Amended 12/18/87 as WCD Admin. Order 4-1987, eff. 1/1/88

**REQUEST FOR CONSENT TO SUSPENSION OF COMPENSATION; WORKER'S FAILURE
OR REFUSAL TO SUBMIT TO MEDICAL EXAMINATION**

436-60-090 (1) A worker shall submit to medical examination at a time and, from time to time, at a place reasonably convenient for the worker when requested to do so by the Director or insurer. However, no more than three separate medical examinations at different times, may be requested during the life of the claim, except after notification to and authorization by the Director pursuant to OAR 436-10.

(2) If an issue to be clarified by the scheduled examination is the necessity of continued treatment in the recovery process, and the worker fails or refuses to be examined, further treatment can be suspended by order of Compliance pending cooperation by the worker.

(3) The Director or insurer shall notify the worker, and the worker's attorney if represented, in writing at least 10 days prior to the examination to ensure receipt of the notice of the following:

- (a) name of the examining physician or facility;
- (b) the purpose of the examination;
- (c) the date, time and place of the examination;
- (d) the attending physician was notified of the examination;
- (e) when required, the medical director has approved the examination;

(f) that the reasonable cost of public transportation or use of a private vehicle will be reimbursed and, that when necessary, reasonable cost of child care, meals, lodging and other related services will be reimbursed. A request for reimbursement must be accompanied by a sales slip, receipt or other evidence necessary to support the request. Should an advance of these costs be necessary for attendance, a request for advancement shall be made in sufficient time to ensure a timely appearance; and

- (g) in prominent or bold-face type the paragraph:

"ATTENDANCE OF THIS EXAMINATION IS MANDATORY. YOU ARE RESPONSIBLE FOR NOTIFYING US PRIOR TO THE DATE OF THE EXAMINATION OF ANY REASON WHY YOU CANNOT ATTEND AS SCHEDULED. FAILURE TO ATTEND THIS EXAMINATION, OR COOPERATE IN THE EXAMINATION, OR AN INVALID REASON FOR NOT ATTENDING SHALL RESULT IN SUSPENSION OF YOUR COMPENSATION BENEFITS PURSUANT TO ORS 656.325 and OAR 436-60."

(4) The Director or insurer upon receipt from the worker of a valid reason for not attending a scheduled examination or not completing an authorized program shall determine whether to reschedule same. If the examination is to be rescheduled, the Department or insurer shall immediately reschedule the

worker for the requested examination as soon as possible in the future and consistent with the ability of the worker to submit to such examination.

(5) The Director or insurer shall verify by direct telephone communication with the examining physician, facility or with the staff of such physician or of such facility on the day scheduled for the examination that the worker did submit to the examination or that the worker failed to submit to examination.

(6) The insurer requesting consent to suspension of compensation because of a worker's failure or refusal to submit to a medical examination, or obstruction of same, shall apply to Compliance. A copy of the application request shall be delivered to the worker at the last known address by registered or certified mail with return receipt requested or by personal service meeting the requirements for service of a summons, and to the worker's attorney if represented. The application in letter form shall contain the following information:

(a) consent for suspension of compensation is requested pursuant to ORS 656.325 and OAR 436-60;

(b) what the worker was requested to submit to;

(c) the dates of all prior examinations scheduled by the insurer and the physician seen. If none, so state. If medical director's approval was obtained, provide a copy of the approval. If the current examination is by a consulting physician, written documentation of the physician's referral must be provided;

(d) that the worker failed or refused to be examined and any reason given by the worker why the examination could not be attended as scheduled. If a reason was provided but is considered invalid, explain;

(e) the date that verification of failure to attend was obtained from the examining physician, facility or their staff. Any delay in obtaining verification or in requesting consent for suspension of compensation may result in authorization being denied or the date of authorization be modified by the date of actual verification or the date the request is received by Compliance;

(f) whether an examination will be rescheduled and, if so, the date, time and place of any rescheduled examination;

(g) any pertinent information that supports the request for suspension of compensation; and

(h) in prominent or bold-faced type the paragraph:

"NOTICE TO WORKER: IF YOU THINK THIS APPLICATION FOR SUSPENSION OF COMPENSATION IS NOT RIGHT YOU MAY RESPOND IN WRITING TO THE COMPLIANCE SECTION, WORKERS' COMPENSATION DIVISION, DEPARTMENT OF INSURANCE AND FINANCE, LABOR & INDUSTRIES BUILDING, SALEM, OREGON 97310. YOUR RESPONSE MUST BE RECEIVED BY THE DEPARTMENT WITHIN 10 WORKING DAYS OF THE DATE OF THIS NOTICE."

(7) The application to Compliance shall be accompanied by a copy of the letter required in section (3) sent to the worker.

(8) Compliance shall consider all documentation and correspondence submitted by the insurer and worker. If the evidence supports the application, Compliance shall issue an order consenting to the suspension of compensation by the insurer from a date prescribed in subsection (6)(e) of this rule and until such time as the worker has submitted to an examination scheduled by the Director or insurer.

(9) The Compliance order consenting to the suspension of compensation by an insurer shall contain a notice, in prominent or bold-face type, as follows:

"IF YOU THINK THIS ORDER IS NOT RIGHT YOU MAY REQUEST A RECONSIDERATION OR A HEARING. REQUEST FOR RECONSIDERATION MUST BE IN WRITING AND SENT TO THE COMPLIANCE SECTION, WORKERS' COMPENSATION DIVISION, DEPARTMENT OF INSURANCE AND FINANCE, LABOR & INDUSTRIES BLDG., SALEM, OR 97310. HEARING REQUESTS MUST BE SENT TO THE HEARINGS DIVISION, WORKERS' COMPENSATION BOARD, 480 CHURCH STREET SE, SALEM, OR 97310."

(10) The Director or insurer shall verify when the worker has submitted to the rescheduled examination and shall immediately notify Compliance, by letter, of the worker's attendance and that compensation has resumed as of the date of the examination.

(11) The insurer may request an administrative order of closure be issued by Evaluation if the worker has made no effort to have compensation reinstated within 60 days after Compliance has authorized suspension of compensation.

Hist: Filed 12/11/70 as WCB Admin. Order 16-1970
Amended 4/27/78 as WCD Admin. Order 6-1978, eff. 4/27/78
Amended 1/11/80 as WCD Admin. Order 1-1980, eff. 1/11/80
Amended 12/23/81 as WCD Admin. Order 6-1981, eff. 1/1/82
Amended 12/29/83 as WCD Admin. Order 8-1983, eff. 1/1/84
Renumbered from 436-54-283, May 1, 1985
Amended 12/12/85 as WCD Admin. Order 8-1985, eff. 1/1/86
Amended 12/18/87 as WCD Admin. Order 4-1987, eff. 1/1/88

REQUEST FOR CONSENT TO SUSPENSION OF COMPENSATION; WORKER'S FAILURE TO PARTICIPATE IN A PHYSICAL REHABILITATION PROGRAM

436-60-100 (1) A worker is required to participate in a physical rehabilitation program. A notice of such program issued by an insurer shall include a notice as described in section (2) informing the worker that failure to participate in the program shall result in suspension of compensation.

(2) The Director or insurer shall notify the worker, and the worker's attorney if represented, in writing at least 10 days prior to the start of a program of physical rehabilitation to ensure receipt of the notice of the following:

(a) purpose of the program;

(b) the date, time and place of the program;

(c) the attending physician was notified of the program;

(d) that the reasonable cost of public transportation or use of a private vehicle will be reimbursed and, that when necessary, reasonable cost of child care, meals, lodging and other related services will be reimbursed. A request for reimbursement must be accompanied by a sales slip, receipt or other evidence necessary to support the request. Should an advance of these costs be necessary for attendance, a request for advancement shall be made in sufficient time to ensure a timely appearance; and

(e) in prominent or bold-face type the paragraph:

"ATTENDANCE AND PARTICIPATION IS REQUIRED IN A PROGRAM OF PHYSICAL REHABILITATION. FAILURE TO PARTICIPATE SHALL RESULT IN SUSPENSION OF YOUR COMPENSATION BENEFITS AND POSSIBLE REDUCTION OF ANY PERMANENT DISABILITY AWARDED PURSUANT TO ORS 656.325 and OAR 436-60."

(3) The Director or insurer upon receipt from the worker of a valid reason for not participating in a physical rehabilitation program shall determine whether to reschedule or continue same. If the program is to be rescheduled it shall be rescheduled as soon as possible in the future and consistent with the ability of the worker to participate in the program.

(4) The notice in section (2) will not be required to be repeated once the worker has agreed to participate in a physical rehabilitation program and then elects to withdraw after the specified date.

(5) The insurer requesting consent to suspension of compensation because of a worker's failure or refusal to participate in a program of physical rehabilitation, or obstruction of same, shall apply to Compliance. A copy of the application request shall be delivered to the worker at the last known address by registered or certified mail with return receipt requested or by personal service meeting the requirements for service of a summons, and to the worker's attorney if represented. The application in letter form shall contain the following information:

(a) consent for suspension of compensation is requested pursuant to ORS 656.325 and OAR 436-60;

(b) what actions of the worker initiated the request for suspension of compensation;

(c) any reason given by the worker for failure or refusal to participate in the program, or obstruction of same;

(d) the date that failure by the worker to participate in a physical rehabilitation program was verified and with whom or how verified. Such verification is required to be made immediately and any delay can result in suspension of compensation not being authorized until the actual date of verification, the date the request is received by Compliance, or not at all;

(e) whether the program will be rescheduled and, if so, the date and place;

(f) any pertinent information that supports the request for suspension of compensation; and

(g) a notice, in prominent or bold-faced type, as follows:

"NOTICE TO WORKER: IF YOU THINK THIS APPLICATION FOR SUSPENSION OF COMPENSATION IS NOT RIGHT, YOU MAY RESPOND IN WRITING TO THE COMPLIANCE SECTION, WORKERS' COMPENSATION DIVISION, DEPARTMENT OF INSURANCE AND FINANCE, LABOR & INDUSTRIES BUILDING, SALEM, OREGON 97310. YOUR RESPONSE MUST BE RECEIVED BY THE DEPARTMENT WITHIN 10 WORKING DAYS OF THE DATE OF THIS NOTICE."

(6) The application to Compliance shall be accompanied by a copy of the letter required in section (2) sent to the worker.

(7) Compliance shall consider all documentation and correspondence submitted by the insurer and worker. If the evidence supports the application, Compliance shall issue an order consenting to suspension of compensation by the insurer from a date prescribed in subsection (5)(d) of this rule and until such time as the worker participates in a program or such program is determined inappropriate.

(8) The Compliance order consenting to the suspension of compensation by an insurer shall contain a notice, in prominent or bold-face type, as follows:

"IF YOU THINK THIS ORDER IS NOT RIGHT YOU MAY REQUEST A RECONSIDERATION OR A HEARING. REQUEST FOR RECONSIDERATION MUST BE IN WRITING AND SENT TO THE COMPLIANCE SECTION, WORKERS' COMPENSATION DIVISION, DEPARTMENT OF INSURANCE AND FINANCE, LABOR & INDUSTRIES BLDG., SALEM, OR 97310. HEARINGS REQUESTS MUST BE SENT TO THE HEARINGS DIVISION, WORKERS' COMPENSATION BOARD, 480 CHURCH STREET SE, SALEM, OR 97310."

(9) The insurer shall notify Compliance by letter when the worker participates in a program, and that compensation has resumed.

(10) The insurer may request an administrative order of closure be issued by Evaluation if the worker has made no effort to have compensation reinstated within 60 days after the authorization of consent to the suspension of compensation.

Hist: Filed 12/23/81 as WCD Admin. Order 6-1981, eff. 1/1/82
Amended 12/29/83 as WCD Admin. Order 8-1983, eff. 1/1/84
Renumbered from 436-54-284, May 1, 1985
Amended 12/12/85 as WCD Admin. Order 8-1985, eff. 1/1/86
Amended 12/18/87 as WCD Admin. Order 4-1987, eff. 1/1/88

REQUEST FOR CONSENT TO SUSPENSION OF COMPENSATION; WORKER'S COMMISSION OF INSANITARY OR INJURIOUS PRACTICES

436-60-110 (1) The insurer shall upon knowledge of a worker committing insanitary or injurious practices which tends to either imperil or retard recovery request in writing to the worker that such practices stop. The

letter to the worker with copy to the worker's attorney if represented, shall explain:

(a) the insanitary or injurious practices being committed;

(b) that such practices are considered insanitary or injurious by the attending physician;

(c) that such practices stop by a specified date in the reasonable future and remain stopped; and

(d) in prominent or bold-face type the paragraph:

"COMMITTING OF SUCH INSANITARY OR INJURIOUS PRACTICES BEYOND THE DATE INDICATED SHALL RESULT IN SUSPENSION OF COMPENSATION BENEFITS AND POSSIBLE REDUCTION OF ANY PERMANENT DISABILITY AWARDED PURSUANT TO ORS 656.325 AND OAR 436-60."

(2) The insurer shall verify on the specified date whether the worker did or did not stop the insanitary or injurious practices and, if stopped, periodically check to see that such practices remain stopped.

(3) The insurer will not be required to repeat the request in section (1) once the injured worker has been put on notice and again commits the same insanitary or injurious practices after the specified date.

(4) The insurer requesting consent to suspension of compensation because of a worker's failure to stop insanitary or injurious practices, shall apply to Compliance. A copy of the application request shall be delivered to the worker at the last known address by registered or certified mail with return receipt requested or by personal service meeting the requirements for service of a summons, and to the worker's attorney if represented. The application in letter form shall contain the following information:

(a) consent for suspension of compensation is requested pursuant to ORS 656.325 and OAR 436-60;

(b) explanation of the insanitary or injurious practice being committed by the worker;

(c) whether or not the attending physician considers the practices to be insanitary or injurious to the worker;

(d) that the worker continues the insanitary or injurious practices after the date specified in the letter to the worker;

(e) the date that failure by the worker to stop the practices was verified and with whom or how verified. Any delay in obtaining verification or in requesting consent for suspension of compensation may result in authorization being denied or the date of authorization being modified by the date of actual verification or the date the request is received by Compliance;

(f) any pertinent information that supports the request for suspension of compensation; and

(g) in prominent or bold-faced type the paragraph:

"NOTICE TO WORKER: IF YOU THINK THIS APPLICATION FOR SUSPENSION OF COMPENSATION IS NOT RIGHT, YOU MAY RESPOND IN WRITING TO THE COMPLIANCE SECTION, WORKERS' COMPENSATION DIVISION, DEPARTMENT OF INSURANCE AND FINANCE, LABOR & INDUSTRIES BUILDING, SALEM, OREGON 97310. YOUR RESPONSE MUST BE RECEIVED BY THE DEPARTMENT WITHIN 10 WORKING DAYS OF THE DATE OF THIS NOTICE."

(5) The application to Compliance shall be accompanied by a copy of the letter required in section (1) sent to the worker.

(6) Compliance shall consult with the Medical Director to review whether the practices are insanitary or injurious to the worker's recovery.

(7) Compliance shall issue an order consenting to the suspension of compensation by an insurer for any period of time during which a worker commits any insanitary or injurious practice which tends to either imperil or retard recovery. The consent to suspension of compensation shall continue until the date the worker has, in fact, demonstrated termination of such practices to the insurer and no compensation shall be due or paid during such period.

(8) The Compliance order consenting to the suspension of compensation by an insurer shall contain a notice, in prominent or bold-face type, as follows:

"IF YOU THINK THIS ORDER IS NOT RIGHT YOU MAY REQUEST A RECONSIDERATION OR A HEARING. REQUEST FOR RECONSIDERATION MUST BE IN WRITING AND SENT TO THE COMPLIANCE SECTION, WORKERS' COMPENSATION DIVISION, DEPARTMENT OF INSURANCE AND FINANCE, LABOR & INDUSTRIES BLDG., SALEM, OR 97310. HEARING REQUESTS MUST BE SENT TO THE HEARINGS DIVISION, WORKERS' COMPENSATION BOARD, 480 CHURCH STREET SE, SALEM, OR 97310."

(9) The insurer shall continually monitor the claim to ascertain when the worker has, in fact, stopped committing the insanitary or injurious practices. When it is established that the practices have stopped, payment of compensation benefits shall commence effective on that date and the insurer shall immediately notify Compliance by letter of the date of resumption.

(10) The insurer may request an administrative order of closure be issued by Evaluation if the worker has made no effort to have compensation reinstated within 60 days after Compliance has authorized suspension of compensation.

Hist: Filed 12/11/70 as WCB Admin. Order 16-1970
Amended 4/27/78 as WCD Admin. Order 6-1978, eff. 4/27/78
Amended 1/11/80 as WCD Admin. Order 1-1980, eff. 1/11/80
Amended 12/23/81 as WCD Admin. Order 6-1981, eff. 1/1/82
Amended 12-29-83 as WCD Admin. Order 8-1983, eff. 1-1-84
Renumbered from 436-54-285, May 1, 1985
Amended 12/12/85 as WCD Admin. Order 8-1985, eff. 1/1/86
Amended 12/18/87 as WCD Admin. Order 4-1987, eff. 1/1/88

REQUEST FOR CONSENT TO SUSPENSION OF COMPENSATION; WORKER'S
REFUSAL TO SUBMIT TO MEDICAL OR SURGICAL TREATMENT

436-60-120 (1) The insurer shall upon knowledge of worker refusing to submit to such medical or surgical treatment as is reasonably essential to promote recovery, request in writing to the worker that such treatment be obtained. The letter to the worker, with copy to the worker's attorney if represented, shall explain:

(a) the need for the recommended medical or surgical treatment;

(b) that such treatment is considered reasonably essential to promote the worker's recovery;

(c) that notice of consent for such treatment be given to the insurer by a specified date in the reasonable future; and

(d) in prominent or bold-face type the paragraph:

"THE DECISION WHETHER TO RECEIVE MEDICAL OR SURGICAL TREATMENT CONSIDERED REASONABLY ESSENTIAL TO PROMOTE RECOVERY IS A DECISION OF THE INJURED WORKER. FAILURE, HOWEVER, TO GIVE CONSENT BY THE DATE INDICATED OR FAILURE TO ACTUALLY RECEIVE SUCH TREATMENT SHALL RESULT IN SUSPENSION OF YOUR COMPENSATION BENEFITS AND POSSIBLE REDUCTION OF ANY PERMANENT DISABILITY AWARDED PURSUANT TO ORS 656.325 and OAR 436-60."

(2) For the purpose of this section failure of the worker to remain under a doctor's care, seek reasonable periodic examinations or participate in a treatment regimen shall be considered failure or refusal to submit to medical treatment.

(3) The insurer shall verify on the specified date whether the worker did or did not give consent for the recommended medical or surgical treatment.

(4) The insurer will not be required to repeat the request in section (1) once the injured worker has given consent for the recommended medical or surgical treatment and then elects to withdraw the consent after the specified date.

(5) The insurer requesting consent to suspension of compensation because of a worker's refusal to submit to recommended medical or surgical treatment, shall apply to Compliance. A copy of the application request shall be delivered to the worker at the last known address by registered or certified mail with return receipt requested or by personal service meeting the requirements for service of a summons, and to the worker's attorney if represented. The application in letter form shall contain the following information:

(a) consent for suspension of compensation is requested pursuant to ORS 656.325 and OAR 436-60;

(b) explanation of the recommended medical or surgical treatment;

(c) whether or not the attending physician considers the treatment reasonably essential to promote the worker's recovery;

(d) that the worker has refused and continues to refuse to submit to the recommended treatment after the date specified in the letter to the worker;

(e) any reason given by the worker for refusing to submit to the recommended medical or surgical treatment;

(f) the date that failure by the worker to give consent for the treatment was verified and with whom or how verified. Such verification is required to be made immediately and any delay can result in suspension of compensation not being authorized until the actual date of verification, the date the request is received by Compliance, or not at all; and

(g) in prominent or bold-faced type the paragraph:

"NOTICE TO WORKER: IF YOU THINK THIS APPLICATION FOR SUSPENSION OF COMPENSATION IS NOT RIGHT YOU MAY RESPOND IN WRITING TO THE COMPLIANCE SECTION, WORKERS' COMPENSATION DIVISION, DEPARTMENT OF INSURANCE AND FINANCE, LABOR & INDUSTRIES BUILDING, SALEM, OREGON 97310. YOUR RESPONSE MUST BE RECEIVED BY THE DEPARTMENT WITHIN 10 WORKING DAYS OF THE DATE OF THIS NOTICE."

(6) The insurer shall provide documentation to adequately demonstrate that the medical or surgical treatment is reasonably essential to promotion of the worker's recovery and that the need for such medical or surgical treatment has been fully explained to the worker by the physician recommending such treatment. Documentation should consist of doctor's reports, copies of correspondence, reports of consultation on the medical or surgical treatment recommended or any other written evidence which demonstrates the recommended treatment is reasonably essential.

(7) The application to Compliance shall be accompanied by a copy of the letter required in section (1) sent to the worker.

(8) Compliance shall consult with the Medical Director to review whether the recommended treatment is reasonably essential to promote the worker's recovery.

(9) Compliance shall issue an order consenting to the suspension of compensation by an insurer for any period of time during which a worker refuses to submit to recommended medical or surgical treatment reasonably essential to promote recovery. The consent to suspension of compensation shall continue until the date the worker has, in fact, consented to the recommended medical or surgical treatment and no compensation shall be due or paid during such period. When the worker has established a pattern of noncooperation, Compliance may require the worker to begin recommended treatment before compensation shall be restarted.

(10) The insurer shall continually monitor the claim to ascertain when the worker has, in fact, consented to the recommended medical or surgical

treatment. When it is established that consent has been given, payment of compensation benefits shall commence effective on the date the consent was given and the insurer shall immediately notify Compliance by letter of the date of resumption.

(11) The insurer may request an administrative order of closure be issued by Evaluation if the worker has made no effort to have compensation reinstated within 60 days after Compliance has authorized suspension of compensation.

(12) The Compliance order consenting to the suspension of compensation by an insurer shall contain a notice, in prominent or bold-face type, as follows:

"IF YOU THINK THIS ORDER IS NOT RIGHT YOU MAY REQUEST A RECONSIDERATION OR A HEARING. REQUEST FOR RECONSIDERATION MUST BE IN WRITING AND SENT TO THE COMPLIANCE SECTION, WORKERS' COMPENSATION DIVISION, DEPARTMENT OF INSURANCE AND FINANCE, LABOR & INDUSTRIES BLDG., SALEM, OR 97310. HEARING REQUESTS MUST BE SENT TO THE HEARINGS DIVISION, WORKERS' COMPENSATION BOARD, 480 CHURCH STREET SE, SALEM, OR 97310."

(13) When the suspension is not approved, Compliance shall notify the insurer of the reason for denial.

Hist: Filed 12/11/70 as WCB Admin. Order 16-1970
Amended 4/27/78 as WCD Admin. Order 6-1978, eff. 4/27/78
Amended 1/11/80 as WCD Admin. Order 1-1980, eff. 1/11/80
Amended 12/23/81 as WCD Admin. Order 6-1981, eff. 1/1/82
Amended 12/29/83 as WCD Admin. Order 8-1983, eff. 1/1/84
Renumbered from 436-54-286, May 1, 1985
Amended 12/12/85 as WCD Admin. Order 8-1985, eff. 1/1/86
Amended 12/18/87 as WCD Admin. Order 4-1987, eff. 1/1/88

**PETITION FOR REDUCTION OF BENEFITS; WORKER'S FAILURE TO FOLLOW
MEDICAL ADVICE OR PARTICIPATE IN OR COMPLETE PHYSICAL RESTORATION
OR VOCATIONAL REHABILITATION PROGRAMS OR COMMISSION OF INSANITARY
OR INJURIOUS PRACTICES**

436-60-130 (1) The Director or insurer which determines that a worker has failed to follow the medical advice of the attending physician or has committed an insanitary or injurious practice or has failed to participate in or complete physical restoration or vocational rehabilitation programs may petition for a reduction of benefits awarded the worker when determination is made pursuant to ORS 656.268.

(a) The petition for reduction of benefits will be sent to Evaluation.

(b) The petition shall contain all pertinent facts necessary to support the action requested and shall be accompanied by documentation to adequately demonstrate the worker's commission of an insanitary or injurious practice or failure to follow the attending physician's medical advice or participate in or complete physical restoration or vocational rehabilitation programs. Documentation may consist of telephone memoranda, doctor's reports, copies of correspondence, investigative reports or any other written evidence of the worker's failure to cooperate.

(2) Evaluation shall, in the absence of a petition from an employer or an insurer, reduce a worker's benefits when it comes to the attention of Evaluation that the worker has committed an insanitary or injurious practice or failed to follow the medical advice of the attending physician or has failed to participate in or complete physical restoration or vocational rehabilitation programs. Evaluation, if necessary, may require other information from the insurer to adequately demonstrate the worker's commission of an insanitary or injurious practice or failure to follow the attending physician's medical advice or participate in or complete physical restoration or vocational rehabilitation programs prescribed for the worker pursuant to ORS Chapter 656 and WCD Administrative Rules.

(3) Evaluation shall, upon determination of the worker's claim pursuant to ORS 656.268 and after considering any petition for reduction of benefits as described in section (1) or under the provisions of section (2), reduce the benefits awarded by the amount the disability has been increased by the worker's commission of an insanitary or injurious practice or failure to follow medical advice from his attending physician or to participate in or complete physical restoration or vocational rehabilitation programs. Any reduction shall be demonstrated in the Determination Order by the amount of disability which would have been awarded and the amount of the award ultimately resulting from the worker's failure to cooperate.

Hist: Filed 12/11/70 as WCB Admin. Order 16-1970
Amended 4/27/78 as WCD Admin. Order 6-1978, eff. 4/27/78
Amended 1/11/80 as WCD Admin. Order 1-1980, eff. 1/11/80
Amended 12/23/81 as WCD Admin. Order 6-1981, eff. 1/1/82
Amended 12/29/83 as WCD Admin. Order 8-1983, eff. 1/1/84
Renumbered from 436-54-287, May 1, 1985
Amended 12/12/85 as WCD Admin. Order 8-1985, eff. 1/1/86
Amended 12/18/87 as WCD Admin. Order 4-1987, eff. 1/1/88

ACCEPTANCE OR DENIAL OF A CLAIM

436-60-140 (1) Written notice of acceptance or denial of a claim shall be furnished to the claimant by the insurer within 60 days after the employer has notice or knowledge of the claim.

(2) Any insurer who is delinquent in accepting or denying a claim beyond the statutory 60 days in excess of 5 percent of their total volume of reported claims during any quarter may receive a penalty assessed by the Director.

(3) The notice of acceptance in compliance with ORS 656.262 and the rules of Practice and Procedure for Contested Cases under the Workers' Compensation Law shall:

(a) inform the worker whether the claim is considered disabling or nondisabling;

(b) inform the worker of the Expedited Claim Service, of hearing and aggravation rights concerning nondisabling injuries including the right to object to a decision that the injury is nondisabling by requesting a determination pursuant to ORS 656.268;

(c) inform the worker of employment reinstatement rights and responsibilities under ORS Chapter 659;

(d) inform the worker of assistance available to employers from the Workers' Reemployment Reserve under ORS 656.622; and

(e) inform the worker that expenses personally paid for claim related expenses up to a maximum established rate shall be reimbursed by the insurer when requested in writing and accompanied by sales slips, receipts, etc., for meals, lodging, transportation, prescriptions and other expenses.

(4) The notice of denial in compliance with the rules of Practice and Procedure for Contested Cases under the Workers' Compensation Law shall:

(a) specify the factual and legal reasons for denial; and

(b) inform the worker of the Expedited Claim Service and of hearing rights under ORS 656.283.

(5) The insurer shall send notice of the denial to each provider of medical services and health insurance when compensability of all, or any portion, of a claim for medical services is denied. When the compensability issue has been finally determined the insurer shall notify each affected medical service provider and each health insurance provider of the results of the determination, including the results of proceedings under ORS 656.289(4) and the amount of any settlement.

(6) The insurer shall or the employer may make payment of compensation due pursuant to ORS 656.262 and 656.273 and continue until such time as the claim is denied, except where there is an issue concerning the timely filing of a notice of accident as provided in ORS 656.265(4). The insurer shall report to Compliance payments of compensation made by the employer as if the insurer had made the payment.

(7) Pending acceptance or denial of a claim, compensation payable to a worker or the worker's beneficiaries does not include the costs of medical benefits or burial expense.

Hist: Filed 1/11/80 as WCD Admin. Order 1-1980, eff. 1/11/80
Amended 12/23/81 as WCD Admin. Order 6-1981, eff. 1/1/82
Amended 12/29/83 as WCD Admin. Order 8-1983, eff. 1/1/84
Renumbered from 436-54-300, May 1, 1985
Amended 12/12/85 as WCD Admin. Order 8-1985, eff. 1/1/86
Amended 12/18/87 as WCD Admin. Order 4-1987, eff. 1/1/88

TIMELY PAYMENT OF COMPENSATION

436-60-150 (1) Benefits shall be deemed paid when deposited in the U.S. Mail addressed to the last known address of the worker or beneficiary. Notice of the method and manner of such payment shall be provided as prescribed by the Director.

(2) The acceptable timeliness of first payment of time loss by the employer or insurer shall be no less than the previous fiscal year's average of the respective entities rounded to the nearest 5th percentage point, but in no event less than 80% for a guaranty contract insurer and 90% for a self-insured employer. An insurer falling below these norms during any quarter may receive a penalty assessed by the Director.

(3) Timely payment of temporary disability benefit has been made when paid no later than the 14th day after:

(a) employer's notice or knowledge of the claim if temporary disability is immediate and payable;

(b) employer's notice or knowledge of temporary disability related to but subsequent to the injury, which is payable;

(c) start of vocational training, if a claim has previously been determined;

(d) date the subject employer, or their insurer, has notice or knowledge of medically verified inability to work due to an aggravation of the worker's condition;

(e) date of any determination or litigation order which orders temporary disability;

(f) date a claim has been referred by the Department to the insurer for processing pursuant to ORS 656.029; or

(g) date a noncomplying employer claim has been referred by the Department to the SAIF Corporation.

(4) Continued temporary disability due shall be paid to within 7 days of the date of payment at least once each 14 days thereafter. The employer, when making payments as provided in OAR 436-60-020(1), may make subsequent payments of temporary disability concurrently with the normal payroll schedule of the employer, rather than in the regular 14-day intervals.

(5) Timely payment of permanent disability benefit has been made when paid no later than the 30th day after:

(a) date of determination order by the Department or notice of claim closure by the insurer; or

(b) date of any litigation order which orders permanent disability.

(6) Subsequent payments of permanent disability benefits are made in monthly sequence as earned. Adjustments to monthly payment dates may be made by the insurer, but the worker shall be advised of the adjustment, and no payment period shall exceed one month.

(7) Timely payment of medical services or goods shall be deemed made when paid within 60 days of the receipt of statement. When there is a dispute over

the amount of a bill or the necessity of services rendered, the insurer will pay the undisputed amount. Resolution of the disputed amount will be made in accordance with OAR 436-10.

(8) The insurer shall notify the claimant or provider of service in writing when compensation is paid of the specific purpose of the payment. When applicable, the notice shall indicate the time period for which the payment is made and the reimbursable expenses or other bills and charges covered. If any portion of the claim is denied, the notice shall identify that portion of the claimed amounts that is not being paid.

Amended 1/11/80 as WCD Admin. Order 1-1980, eff. 1/11/80
Amended 12/23/81 as WCD Admin. Order 6-1981, eff. 1/1/82
Amended 12/29/83 as WCD Admin. Order 8-1983, eff. 1/1/84
Renumbered from 436-54-310, May 1, 1985
Amended 12/12/85 as WCD Admin. Order 8-1985, eff. 1/1/86
Amended 12/18/87 as WCD Admin. Order 4-1987, eff. 1/1/88

USE OF SIGHT DRAFT TO PAY COMPENSATION PROHIBITED

436-60-160 A sight draft shall not be used to make payment of any benefits due a worker or beneficiary under ORS Chapter 656. Such benefits include temporary disability, permanent disability and reimbursement of costs paid directly by the worker.

Hist: Filed 12/19/75 as WCB Admin. Order 18/1975, eff. 1/1/76
Amended 4/27/78 as WCD Admin. Order 6-1978, eff. 4/27/78
Amended 1/11/80 as WCD Admin. Order 1-1980, eff. 1/11/80
Amended 12/29/83 as WCD Admin. Order 8-1983, eff. 1/1/84
Renumbered from 436-54-315, May 1, 1985
Amended 12/12/85 as WCD Admin. Order 8-1985, eff. 1/1/86

RECOVERY OF OVERPAYMENT OF BENEFITS

436-60-170 (1) Insurers may recover overpayment of benefits paid to a worker through the procedure specified by ORS 656.268(10).

(2) Recovery of overpayment by the insurer shall be explained in written form to the worker, and the worker's attorney if represented, or to the dependent(s) of the worker if a fatality, and include:

- (a) an explanation for the reason of overpayment;
- (b) the amount of the overpayment; and
- (c) the method of recovery of the overpayment.

Hist: Filed 1/11/80 as WCD Admin. Order 1-1980, eff. 1/11/80
Amended 12/23/81 as WCD Admin. Order 6-1981, eff. 1/1/82
Amended 12/29/83 as WCD Admin. Order 8-1983, eff. 1/1/84
Amended 4/4/84 as WCD Admin. Order 3-1984, eff. 4/4/84
Renumbered from 436-54-320, May 1, 1985
Amended 12/12/85 as WCD Admin. Order 8-1985, eff. 1/1/86
Amended 12/18/87 as WCD Admin. Order 4-1987, eff. 1/1/88

DESIGNATION AND RESPONSIBILITY OF A PAYING AGENT

436-60-180 (1) For the purpose of this rule:

(a) "Compensable injury" means an accidental injury, or accidental injury to prosthetic appliances, arising out of and in the course of employment requiring medical services or resulting in disability or death; an injury is accidental if the result is an accident, whether or not due to accidental means.

(b) "Responsibility" means liability under the law for the acceptance and processing of a compensable injury claim.

(2) Compliance shall, by order, designate who shall pay a claim, if the employers and insurers admit that the claim is otherwise compensable, where there is an issue regarding:

(a) which of several subject employers is the true employer of a claimant worker;

(b) which of more than one insurer of a certain employer is responsible for payment of compensation to a worker;

(c) responsibility between two or more employers or their insurers involving payment of compensation for two or more accidental injuries; or

(d) joint employment by two or more employers.

(3) With the consent of the Workers' Compensation Board, Own Motion claims are subject to the provisions of this rule.

(4) Insurers with knowledge of a situation as defined in section (2) shall expedite the processing of the claim by immediate priority investigation to determine responsibility and whether the claim is otherwise a compensable injury claim.

(5) When a situation as described in section (2) is identified, the insurers shall immediately notify any other affected insurers of the situation. A copy of all medical reports or other pertinent material available relative to the injury shall be provided the other parties with the notification.

(6) Such notice received from another insurer shall be notice of a claim referred by the Director as provided by ORS 656.265(3).

(7) Upon determining an issue exists as to the responsibility for an otherwise compensable injury, an insurer shall request a paying agent be designated by application in letter form to Compliance. The application shall contain the following information:

(a) designation of a paying agent is requested pursuant to ORS 656.307;

(b) acknowledgment that the injury to the worker is otherwise a compensable injury, but

(c) responsibility is an issue;

(d) identification of all parties and claims involved;

(e) acknowledgment that medical reports or other pertinent material available relative to the injury have been provided the other parties; and

(f) acknowledgment that notice has been provided the worker explaining the current actions being taken on the worker's claim.

(8) Compliance shall not designate a paying agent where there remains an issue of whether the injury is a compensable injury claim or if the 60 days appeal period of a denial has expired without a request for a paying agent or a request for a hearing on the denial being received by the Division or Board.

(9) When notified by Compliance that there is a reasonable doubt as to the status of the claim or intent of a denial, the insurers shall provide written clarification to Compliance within 10 days of the date of the notification.

(10) Compliance, upon receipt of a request for designation of a paying agent from the worker or someone on the worker's behalf, shall forward a copy of the request to the insurers involved.

(11) Insurers receiving notice from the Department of a worker's request for designation of a paying agent shall immediately process the request in accordance with sections (4) through (7).

(12) Compliance, upon receipt of written acknowledgment from the insurers that the only issue is responsibility of an otherwise compensable injury claim, shall issue an order designating a paying agent pursuant to ORS 656.307. The insurer paying the lowest temporary disability rate, or if the same, the earliest claim shall be designated the paying agent. The designated paying agent shall make the first payment of temporary disability within 14 days after the date of Compliance order.

(13) Compliance, by copy of its order, shall refer the matter to the Workers' Compensation Board to set an arbitration proceeding pursuant to ORS 656.307 to determine the issue of responsibility of benefits to the worker.

(14) The designated paying agent shall process the claim as an accepted claim through determination unless relieved of the responsibility by an order of the arbitrator. Compensation paid under the order shall include all benefits, including medical services, provided for a compensable injury to a subject worker or the worker's beneficiaries. The payment of temporary disability due shall be for periods subsequent to periods of disability already paid by any insurer.

Hist: Filed 1/11/80 as WCD Admin. Order 1-1980, eff. 1/11/80
Amended 4/29/80 as WCD Admin. Order 5-1980, eff. 4/29/80
(Temporary)

Amended 10/1/80 as WCD Admin. Order 7-1980, eff. 10/1/80
Amended 12/29/83 as WCD Admin. Order 8-1983, eff. 1/1/84
Renumbered from 436-54-332, May 1, 1985
Amended 12/12/85 as WCD Admin. Order 8-1985, eff. 1/1/86
Amended 12/18/87 as WCD Admin. Order 4-1987, eff. 1/1/88

**MONETARY ADJUSTMENTS AMONG PARTIES AND
DEPARTMENT OF INSURANCE AND FINANCE**

436-60-190 (1) An order pursuant ORS 656.307 and OAR 436-60-180 shall apply only to the period prior to the order of the arbitrator determining the responsible paying party. Payment of compensation made thereafter shall not be recovered from the Insurance and Finance Fund, except where the Director concludes payment was made after the date of the order of the arbitrator, but before the order was received by the paying agent designated under OAR 436-60-180.

(2) When all litigation on the issue of responsibility is final, and the responsible paying party has been determined, Compliance shall direct any necessary monetary adjustment between the parties involved which is not ordered or that cannot be voluntarily resolved by the parties. Any failure to obtain reimbursement from an insurer for compensation paid as a result of an order pursuant OAR 436-60-180 shall be recovered from the Insurance and Finance Fund.

(3) When poor or untimely claim processing by the designated paying agent results in unnecessary cost to a claim, Compliance may deny the right to reimbursement for the unnecessary cost from either the responsible paying agent or the Insurance and Finance Fund.

(4) When the responsibility issue is decided by a stipulated settlement, the monetary adjustment between the parties shall not be recovered from the Insurance and Finance Fund.

(5) When the compensability of a claim becomes an issue subsequent to the designation of a paying agent, Compliance shall order termination of any further benefits due from the original order designating a paying agent. The designated paying agent will be responsible for ensuring the issue of responsibility continues to arbitration as well as joining the issue of whether the claim is a compensable injury claim. Failure to seek a conclusion to the issue of responsibility by arbitration shall preclude the designated paying agent from recovering from the Insurance and Finance Fund.

Hist: Filed 6/3/70 as WCB Admin. Order 5-1970
Amended 1/11/80 as WCD Admin. Order 1-1980, eff. 1/11/80
Amended 4/29/80 as WCD Admin. Order 5-1980, eff. 4/29/80
(Temporary)
Amended 10/1/80 as WCD Admin. Order 7-1980, eff. 10/1/80
Amended 12/23/81 as WCD Admin. Order 6-1981, eff. 1/1/82
Amended 12/29/83 as WCD Admin. Order 8-1983, eff. 1/1/84
Renumbered from 436-54-334, May 1, 1985
Amended 12/12/85 as WCD Admin. Order 8-1985, eff. 1/1/86
Amended 12/18/87 as WCD Admin. Order 4-1987, eff. 1/1/88

ASSESSMENT OF CIVIL PENALTIES

436-60-200 (1) The Director through Compliance and pursuant to ORS 656.745 shall assess a civil penalty against an employer or insurer who intentionally or repeatedly induces claimants for compensation to fail to report accidental injuries, causes employes to collect accidental injury claims as off-the-job injury claims, persuades claimants to accept less than the compensation due or makes it necessary for claimants to resort to proceedings against the employer to secure compensation due. For the purpose of this section:

(a) "Intentionally" means the employer or insurer acted with a conscious objective to cause any result described in ORS 656.745(1) or to engage in the conduct so described in that section.

(b) "Repeatedly" means more than once in any twelve month period.

(2) The Director through Compliance and pursuant to ORS 656.745 may assess a civil penalty against an employer or insurer who fails to comply with rules and orders of the Director regarding reports or other requirements necessary to carry out the purposes of the Workers' Compensation Law.

(3) An employer or insurer failing to meet the time frame requirements of Oregon Administrative Rules 436-60-010, 436-60-060, 436-60-070 and 436-60-180 may be assessed a civil penalty up to \$1,000.

(4) An insurer who willfully violates Oregon Administrative Rule 436-60-160 shall be assessed a civil penalty of \$1,000.

(5) Notwithstanding section (3) of this rule, an insurer who does not comply with the claims processing requirements of the statutes, and rules and orders of the Director relating thereto may be assessed a civil penalty of up to \$2,000 for each violation or \$10,000 in the aggregate for all violations within any three month period.

(6) For the purpose of section (5), statutory claims processing requirements would include but not be limited to, ORS 656.202, ORS 656.210, ORS 656.212, ORS 656.228, ORS 656.234, ORS 656.236, ORS 656.245, ORS 656.262, ORS 656.263, ORS 656.264, ORS 656.265, ORS 656.268, ORS 656.273, ORS 656.307, ORS 656.325, ORS 656.331 and ORS 656.335.

(7) In arriving at the amount of penalty Compliance may, but is not limited to, consider:

(a) the ratio of the volume of violations to the volume of claims reported, or

(b) the ratio of the volume of violations to the average volume of violations for all insurers or self-insured employers, and

(c) prior performance in meeting the requirements as outlined in this section.

(8) When a penalty, based upon ratios, is appropriate and the volume to which the volume of errors are compared is 10 or less, Compliance shall assess no more than \$200 regardless of the percentage of error. When, however, the volume exceeds 10 Compliance will assess a penalty of \$25 per percentage point over the acceptable level or \$200 whichever is greater.

Hist: Filed 1/11/80 as WCD Admin. Order 1-1980, eff. 1/11/80
Amended 12/23/81 as WCD Admin. Order 6-1981, eff. 1/1/82
Amended 12/29/83 as WCD Admin. Order 8-1983, eff. 1/1/84
Renumbered from 436-54-981, May 1, 1985
Amended 12/12/85 as WCD Admin. Order 8-1985, eff. 1/1/86
Amended 12/18/87 as WCD Admin. Order 4-1987, eff. 1/1/88

ISSUANCE/SERVICE OF PENALTY ORDERS

436-60-210 (1) When a penalty is assessed as provided by OAR 436-60-200, Compliance shall cause an order, with a notice of the rights provided under ORS 656.740, to be served on the party. If the party requests a hearing on the proposed assessment, Compliance shall furnish the Department of Justice with pertinent records in the matter as requested.

(2) Compliance shall serve the Order:

(a) by delivering a copy of the Order to the party in the manner provided by ORCP 7D.(3); or

(b) by sending a copy of the Order to the party by certified mail with return receipt requested.

Hist: Filed 1/11/80 as WCD Admin. Order 1-1980, eff. 1/11/80
Amended 12/29/83 as WCD Admin. Order 8-1983, eff. 1/1/84
Renumbered from 436-54-983, May 1, 1985
Amended 12/12/85 as WCD Admin. Order 8-1985, eff. 1/1/86
Amended 12/18/87 as WCD Admin. Order 4-1987, eff. 1/1/88

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EXHIBIT "B"

BEFORE THE DIRECTOR OF THE
DEPARTMENT OF INSURANCE AND FINANCE
OF THE STATE OF OREGON

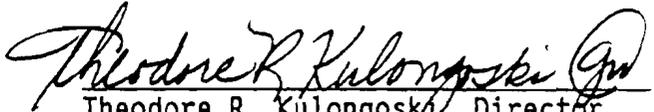
In the Matter of the Amendment)	CITATION OF STATUTORY AUTHORITY,
of Rules Governing Claims)	STATEMENT OF NEED, PRINCIPAL
Administration (OAR Chapter 436,)	DOCUMENTS RELIED UPON, AND
Workers' Compensation Division,)	STATEMENT OF FISCAL IMPACT
Division 60).)	

1. Citation of Statutory Authority. The Statutory Authority for promulgation of these rules is ORS 656.210(2), 656.264, 656.265(6), 656.325, 656.726(3)(a), 656.331 and 656.335.
2. Need for Rules. The need for such rules is to govern the provisions of claims administration in accordance with existing law and statutory amendments passed by the 1987 Legislature.
3. Principal Documents Relied Upon. The commands of the statutes above referenced create the need for these rules. No other principal documents, reports, or studies were relied upon.
4. Fiscal and Economic Impact. The following entities are economically affected: (a) state agencies, in their role of employer; (b) units of local government, in their role of employer; (c) large and small private sector employers subject to the Workers' Compensation Law; and (d) insurance companies processing workers' compensation claims.

The economic effect of promulgating these rules should result in savings to large and small employers within the workers' compensation system. The actual amount cannot be determined, but it could be considerable.

DATED THIS 18 DAY OF DECEMBER, 1987

Department of Insurance and Finance


Theodore R. Kulongoski, Director

