

BEFORE THE DIRECTOR  
OF THE WORKERS' COMPENSATION DEPARTMENT  
OF THE STATE OF OREGON

**FILED**  
DEC 23 1981  
NORMA PAULUS  
SECRETARY OF STATE

In the Matter of the Amendment of )  
OAR Chapter 436, Workers' Compensation )  
Department, Division 54, Rules Governing )  
Claims Administration. )

ORDER OF ADOPTION

RECEIVED

DEC 23 1981

4:36 p.m.  
LEGISLATIVE COUNSEL'S

The Director of the Workers' Compensation Department, pursuant to the rulemaking authority in ORS 656.726(3), and in accordance with the procedure provided by ORS 183.335, amends OAR Chapter 436, Workers' Compensation Department, Division 54, Claims Administration.

On October 5, 1981, the Workers' Compensation Department filed Notice of Public Hearing with the Secretary of State to adopt 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. A copy of the Notice and Proposed Rules were filed with the Legislative Counsel.

Copies of the notice were mailed to interested persons in accordance with OAR 436-90-505 and to those on the Department's distribution mailing list as their interest indicated. The notice was published in the October 15, 1981 Secretary of State's Bulletin.

On November 2, 1981, the public hearing was held. Major issues raised were:

TESTIMONY: Subsection (1) of 54-005, the definition "aggravation" should be redefined to include wording such as "...without the intervention of a new injury...", to eliminate the broadness of the current definition.

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

TESTIMONY: A new Subsection (5) of 54-005 is recommended to add the definition "claim" to provide clarity to a claim being a document in writing.

RESPONSE: The statutory definition of "claim" has been added.

TESTIMONY: Subsection (1) of 54-100 should be amended to require written notice of a claim.

RESPONSE: The statutory definition of a "claim" includes the "notice or knowledge" of a compensable injury by the employer, as well as a written request for compensation from a worker or someone on the worker's behalf. An amendment as recommended would tend to limit this definition.

REC'D W.C.D.

JAN 7 1981

DIRECTOR'S OFFICE

TESTIMONY: Subsection (2) of 54-100 is too harsh in terms of small employers when assessing penalties on 10 percent of total delinquent claims during any quarter.

RESPONSE: The 10 percent as described in 54-100(2) is a scale which the director may use to assess penalties. The wording "may" allows the director to use his discretion in situations where there may only be one claim filed with the employer in a quarter, and that one is delinquent. However, an employer with a small number of claims should have an easier time in reporting all claims timely to their insurer than an employer with a large number of claims. The subsection remains as written.

TESTIMONY: Subsection (4) of 54-100 should be deleted because of being impracticable and too harsh.

RESPONSE: The 10 percent as described in 54-100(4) is a scale which the director may use to assess penalties. The insurers and self-insurers accept the responsibility of reporting to the Department in a manner established by the director. To require less than 100 percent performance would be going against the purpose of the workers' compensation law and the responsibility of the director. The subsection remains as written.

TESTIMONY: Subsection (1) of 54-212 needs to be expanded to provide rules to regulate the performance of the employer in making temporary disability payments directly to the worker.

RESPONSE: Under ORS 656.419(1) the insurer agrees to assume, among other things, prompt payment of all compensation for compensable injuries due workers or their beneficiaries. The insurer is, therefore, responsible for working out procedures between themselves and their insureds when the employer elects to make the payment of temporary disability.

TESTIMONY: Subsection (2) of 54-212 should include a statement where an "offset or credit" may be taken against statutory temporary disability when wages are continued by the employer.

RESPONSE: ORS 656.001 to 656.794 outlines the payments required to be made to the injured worker. ORS 656.018(4), however, provides that nothing in the statute prohibits payment, voluntarily or otherwise, to injured workers in excess of the compensation benefits required to be paid under ORS 656.001 to 656.794. Payment of compensation under ORS 656.262(4) may now be made by the employer if the employer so chooses. When making such payment, the employer shall distinguish between statutory temporary disability and wages when paying both. The temporary disability should be so identified and be exempt of any normal payroll deductions. The subsection remains as written.

TESTIMONY: Subsection (2) of 54-212 should allow continued wages for a given period of time in place of temporary disability.

RESPONSE: The proposed recommendation is contrary to statute. (ORS 656.210)

TESTIMONY: Subsection (2) of 54-212 should provide an offset against temporary disability when an employer is required to pay a worker for a "holiday" due to a union contract.

RESPONSE: The statute outlines the required payments to be made to the worker. A paid holiday would come under ORS 656.018(4) as would paid vacation during a period the worker is receiving temporary disability.

TESTIMONY: Subsection (3)(d) of 54-212 is unfair to employers hiring workers out of a union hall. Workers' compensation should be paid only on actual days of employment rather than on a five day work basis.

RESPONSE: A union worker has no control over the type or length of employment when operating out of a union hall and, therefore, a standard of employment is necessary in carrying out the objectives of the law. The subsection remains as written.

TESTIMONY: Subsection (3)(h) of 54-212 is unfair to employers as a three day a week or less worker is being paid more than the worker's average weekly wage.

RESPONSE: 54-212(3)(h) is a direct quote from ORS 656.210 and cannot be changed by rule.

TESTIMONY: Subsection (3)(i) of 54-212 should be amended to exclude "overtime" and "shift differential" amounts when computing temporary disability if the same is specifically excluded under the terms of a negotiated labor contract.

RESPONSE: This subsection includes overtime only when worked on a regular basis and is considered part of a workers regularly expected wage earnings. This subsection insures uniform claims processing throughout the industry, as well as codifying by rule long standing Department policy. Any conflict with union contracts should be resolved between management and labor. This subsection remains as written.

TESTIMONY: Subsection (4) of 54-212 should be amended to recognize the payment of wages on the initial work day lost.

RESPONSE: The subsection ensures by rule uniform claims processing throughout the industry, as well as codifying by rule long standing Department policy. Any other benefits paid the worker would be considered under ORS 656.018(4). The subsection remains as written.

TESTIMONY: Subsection (6) of 54-212 is outrageous as written and should be rescinded. Time loss is only a way of reimbursing a worker for leaving work to get medical treatment.

RESPONSE: This subsection codifies by rule long standing Department policy and ensures uniform claims processing throughout the industry.

The subsection reflects ORS 656.210 and .212 in that time loss is not payable unless the worker is temporarily disabled, totally or partially. The subsection distinguishes between being physically unable to work, as opposed to being physically unavailable for work, but able. The subsection remains as written.

TESTIMONY: Subsection (3) of 54-222 should be amended to allow an adjustment of temporary disability when a worker is receiving unemployment compensation insurance benefits, as well as temporary total disability.

RESPONSE: The Workers' Compensation Law does not provide for offset against temporary disability when a worker is receiving benefits from more than one source. Such a change would have to be made through legislative action.

TESTIMONY: Subsection (3) of 54-222 should be amended to allow adjustment of temporary disability when a worker released to modified employment is included in a general layoff. The worker should continue to receive temporary partial disability as if the worker was still working.

RESPONSE: A worker who is released to only modified employment does not have the same advantages as a regular worker in a layoff situation when seeking other temporary or permanent employment. Subsection (3) assumes modified employment is available to the worker. The subsection remains as written.

TESTIMONY: Subsection (5)(a) of 54-222 should retain the requirement the physician be provided a written description of the physical demands of the proposed job offer.

RESPONSE: The subsection is reworded to correspond with the new wording of ORS 656.325(5). The recommendation to include wording such as "...and the physical requirements thereof;" is valid and will be retained in the rules.

TESTIMONY: Subsection (5)(b) & (c) 54-222 should be amended by replacing the wording "... the worker is capable of performing the employment." with "... the offered employment appears to be within the claimant's capabilities". The present wording places the physician in an awkward position and exposes the physician to the risk of medical malpractice.

RESPONSE: The subsection is changed as recommended in the testimony.

TESTIMONY: Subsection (5)(c) of 54-222 should be amended to delete the requirement the worker must be provided a written offer of employment. Such a written requirement would delay the worker's return to employment. Secondly, the requirement to notify the worker of the duration of the offered employment may be unknown at the time of the offer.

RESPONSE: The written offer of employment is only required when the worker refuses wage earning employment. The concern stressed in testimony would not apply in normal offers of employment accepted by the worker. As for the concern over the unknown duration of the offered employment, the worker can be notified of such in the written notice.

TESTIMONY: Subsection (6)(b) of 54-222 would appear unfair in a situation where a worker is discharged due to violation of normal employment rules such as consuming alcoholic beverages. The rule requires temporary total disability to be resumed.

RESPONSE: The intent of 54-222 is to permit normal reduction of temporary disability when a worker refuses wage earning employment. The violation of normal employment standards is another form of refusal. For clarity the wording: (The employer discharging the worker because of violation of normal employment standards shall not be considered a withdrawal of offered employment.) is added before the semi-colon (;) in subsection (6)(b).

TESTIMONY: Subsection (1) of 54-232 should be amended by deleting the final sentence. This will allow reclassification of permanent partial disability payments even when an award has been paid in a lump sum. The current language allows for double payment of compensation to the worker with no right of recovery by the insurer.

RESPONSE: The intent of this subsection is to ensure the worker will receive disability benefits during the period of time it is most needed. Reclassification as recommended would prevent such disability payments. The argument of double payment to the worker is invalid as the permanent partial disability award, in reality, would again be due upon claim closure. The subsection remains as written.

TESTIMONY: Subsection (2) of 54-245 is confusing and should be rewritten to clarify the fact prosthetic devices are only considered if damaged when in use at the time of an industrial accident.

RESPONSE: Subsection (2) has been rewritten to reflect the concerns in the testimony.

TESTIMONY: Subsection (4) of 54-245 is not in accordance with court findings by limiting reimbursement of travel expense to the nearest physician of like services, as well as being beyond the statutory authority of the director.

RESPONSE: The intent of this subsection is not to limit the worker's choice of physicians within the state of Oregon. In the referenced Smith v. Chase Bag Company decision, the courts dealt with a case where the worker began his treatment while he resided near the doctor's office in Molalla and thus found the worker entitled to continue with his treating doctor even after moving to Veneta. Subsection 4 is appropriate and is only amended to the limits of the insurers obligation for transportation.

TESTIMONY: Subsection (4) of 54-245 does not express the point the insurer may select the physician who will treat a claimant outside the state of Oregon.

RESPONSE: 54-245 has been changed to reflect the concern expressed in the testimony.

TESTIMONY: Subsection (5) of 54-245 should be amended to limit the number of physician changes an injured worker can have to the same number of independent evaluations allowed the insurer - three.

RESPONSE: The number of times a worker may change physicians is determined by statute and cannot be changed by rule.

TESTIMONY: Subsection (2) of 54-250 should be amended to permit lump sum payments when the "net amount" owed the claimant does not exceed 32 degrees.

RESPONSE: The statute only provides for lump sum payment when the award for permanent partial disability does not exceed 32 degrees. The proposed recommendation is contrary to the statute. (ORS 656.230)

TESTIMONY: Add a (d) to subsection (7) of 54-250 to stop a lump sum when the insurer or self-insured employer objects to the lump sum.

RESPONSE: The proposed recommendation is contrary to the Workers' Compensation Law. The insurer or self-insured employer has no authority to deny a worker a lump sum payment of an award. The insurer or self-insured employer may offer their objection to a lump sum for the director's consideration.

TESTIMONY: A new section 54-273 on "Aggravation Claims" should be added to clarify what constitutes an aggravation claim and, thus, reduce the amount of litigation caused by the current lack of clarity in the present rules.

RESPONSE: The recommendation in the testimony only reiterates what is already outlined in the statute. A section as recommended in the testimony is not necessary.

TESTIMONY: Add a (e) to subsection (1) of 54-281 to allow suspension of compensation for a worker's refusal to participate in an authorized program of vocational rehabilitation or vocational or job assistance.

RESPONSE: Current rules 54-287 and 61-420 cover a worker who refuses to participate in an authorized program of vocational rehabilitation. An amendment as recommended in the testimony is not necessary.

TESTIMONY: Subsection (1) of 54-283 should be amended to clarify whether the three separate medical examinations are during the entire life of a claim or during each open period of a claim. Also does the referral to the Callahan Center count as an independent examination?

RESPONSE: The subsection is amended to cover the concerns presented in the testimony.

TESTIMONY: Subsection (2)(c) of 54-283 should be amended to include the words "that the" at the beginning of the sentence and "that" after the comma and before "when necessary" appearing on the second line.

RESPONSE: The subsection is amended as recommended in the testimony.

TESTIMONY: Subsection (1) of 54-284 should be clarified to include physical rehabilitation centers other than the Callahan Center, such as pain clinics, or other in-patient and out-patient facilities, and that suspension should be required for withdrawal from a Center.

RESPONSE: The statutory definition describes what a physical rehabilitation center is, and the revised rule 54-284 includes, procedure covering a worker's withdrawal from a Center. The concerns stressed in the testimony are covered by statute and rule.

TESTIMONY: Subsection (1) of 54-284 should clarify the issue whether the worker "needs" a program at a physical rehabilitation center.

RESPONSE: The concerns, as presented in the testimony, come under the Physical Rehabilitation Rules 436-67.

TESTIMONY: Subsection (2)(c) of 54-284 does not provide for how the treating physician can determine a worker's capability to undertake a program until an evaluation is completed.

RESPONSE: The Physical Rehabilitation Services Rules 436-67 provide guidelines and procedures covering the concerns brought out in the testimony.

TESTIMONY: Subsection (9) in the proposed rules or subsection (5) in the staff revised rules of 54-284 does not take into consideration what constitutes a refusal to participate in a program.

RESPONSE: The Administrator of the Callahan Center is charged with the responsibility to determine whether a reason for not participating in a program is valid. An established list of valid reasons is impossible as each case is reviewed on its own merits. The subsection remains as written.

TESTIMONY: Subsection (12) in the proposed rules or subsection (7) in the staff revised rules of 54-284 should be amended by the insertion of the words "of closure" between "order" and "be" on line 2 and the word "suspended" deleted from line 3.

RESPONSE: The subsection is amended as recommended in the testimony, as well as similar subsections in 54-283, 54-285 and 54-286.

TESTIMONY: Subsection (13) in the proposed rules or subsection (8) in the staff revised rules of 54-284 should be amended by deleting the entire first sentence and adding "at the time of closure" between the words "awarded" and "by" on line 4.

RESPONSE: The wording of the subsection is clear. The subsection remains as written.

TESTIMONY: Subsection (14) of 54-286 should be amended to include hearing rights within 30 days of notice for the insurer or self-insured employer when a request for suspension is denied by the Department.

RESPONSE: A party aggrieved by actions in a claim has the right to request a hearing at any time during the life of that claim. Setting a limitation will require legislative action. The subsection remains as written.

TESTIMONY: Subsection (15) of 54-286 should be amended to delete "may" and replace with "shall" to be consistent with the other suspension rules.

RESPONSE: The subsection requires the Evaluation to consider the action of the worker; however, factors in the claim may not require mandatory reduction of benefits. The subsection remains as written.

TESTIMONY: Subsection (2) of 54-305 should be deleted as an up to 25 percent penalty already exists in the statute for untimely accepting or denying a claim. In addition, the 5 percent is inconsistent with the 10 percent of total volume set in the other penalty rules.

RESPONSE: ORS 656.745 allows for the director to assess civil penalties against employers or insurers. Subsection (2) of 54-305 addresses the overall performance of the insurer or self-insured employer in accepting or denying a claim. The statutory requirement is for 100 percent timeliness. The director, however, recognizes there are mitigating circumstances that prevent the realization of 100 percent timeliness. The 5 percent as described in 54-305(2) is a scale which the director may use to assess penalties. Because of the high potential for litigation as a result of untimely accepting or denying a claim, the director feels the 5 percent established for assessing penalties is appropriate in order to limit such litigation. The subsection remains as written.

TESTIMONY: Subsection (3)(c & d) of 54-305 would cause the insurer to become involved in labor codes unless ORS 659 is consolidated with ORS 656.

RESPONSE: The notices are required by statute. (ORS 656.262) The subsection remains as written.

TESTIMONY: Subsection (5) of 54-305 should be amended to include "stipulated" settlements so the health insurance providers are made aware whenever any settlement is reached.

RESPONSE: The subsection reflects the statutory requirement described in ORS 656.313(3). To require the insurer to notify the health insurance providers in such cases where a stipulated settlement is only for increased permanent disability would cause an unnecessary burden on the insurer. The subsection remains as written.

TESTIMONY: Subsection (7) of 54-305 should be amended to include that when a claim is not accepted or denied by the insurer within the 60 days, the claim will be assumed accepted and the insurer liable for payment of all medical costs thus far incurred. In addition, it should be included that an insurer cannot retroactively deny services by issuing a partial denial of such services.

RESPONSE: To do as recommended would be penalizing for untimely accepting or denying of a claim. This is already provided for in ORS 656.262(8) and OAR 436-54-981. The recommended changes are not necessary.

TESTIMONY: Subsection (2) of 54-310 should be amended to set standards that are equal for both the insurer and self-insured employer. The subsection also appears to be redefining statutory time limitations by setting less than 100 percent performance standards.

RESPONSE: The self-insured employer is advantaged by the ability to control reporting, as well as by the fact the claim does not need to be sent to an insurer for processing. The performance standard, therefore, of a self-insured employer should be higher than for an insurer. The setting of the 80 percent and 90 percent as described in 54-310 (2) is a scale which the director may use to assess penalties and does not reflect a redefining of the statutory time limitation. The subsection remains as written.

TESTIMONY: Subsection (4) of 54-310 should be modified to allow subsequent payments of temporary disability prior to the 14 days thereafter provisions.

RESPONSE: The subsection is amended as recommended in the testimony by inserting the words "at least once" between "payment" and "each" on line 2. This amendment is in keeping with the statutory wording in ORS 656.262(4).

TESTIMONY: Subsection (8) of 54-310 should include the following statement: If "reimbursement expenses or other bills and charges covered" include medical expenses, notice shall be given to the health insurance provider. This amendment will cause the health insurance provider to be informed of what bills and when the bills are paid.

RESPONSE: An amendment as recommended in the testimony would require the insurer to be aware of the identity of the health insurance provider, if any, in each and every claim. Such an amendment would cause an almost impossible burden on the insurers. In addition, the director does not have the statutory authority to impose such requirements on the insurers. The subsection shall remain as written.

TESTIMONY: The first paragraph of 54-320 should be amended to include after the word "section" on line 5: "except that any payments made for permanent disability which are held not payable shall be recovered by an off-set against any future permanent disability."

RESPONSE: The recommendation in the testimony exceeds the statutory authority of the director.

TESTIMONY: Subsection (2) of 54-320 should be amended to include informing the dependents of a worker if a fatality claim.

RESPONSE: The subsection is amended as recommended in the testimony by inserting the words "..., or to the dependent(s) of the worker if a fatality," between "worker" and "and" on line 2.

TESTIMONY: Subsection (8) of 54-332 should be amended for clarification purposes by adding "of notification" at the end of the sentence.

RESPONSE: The intent of the subsection was to require clarification within 10 days of the date on the notification. For clarity the words "of the date of the notification" will be added to the subsection.

TESTIMONY: Subsection (1) of 54-334 is unclear when the monetary adjustments take place between the parties.

RESPONSE: The subsection is amended to clarify when monetary adjustments will be made as expressed in the concerns of the testimony by rewording the first sentence to read: "When all litigation on the issue of responsibility is final and the responsible paying party has been determined, the Compliance Division shall direct any necessary monetary adjustment between the parties involved which is not ordered or that cannot be voluntarily resolved by the parties."

TESTIMONY: Subsection (2) of 54-334 should be amended to add the wording "unless the Workers' Compensation Department approved the Stipulation."

RESPONSE: The director does not have the statutory authority to approve stipulated settlements. The subsection remains as written.

TESTIMONY: Subsection (6)(b) of 54-981 should be deleted as the penalty should be measured against each insurer's or self-insured employer's individual performance.

RESPONSE: The subsection 54-981(6)(b) is using a comparison factor of all insurer's and self-insured employer's volume of violations to reach an average of the industry. However, the penalty is assessed only on the insurer's or self-insurer's own individual performance as it relates to this average. The subsection remains as written.

Having reviewed and considered the record of public hearing; and being fully advised, I make the following findings under the authority granted by ORS 656.726(3):

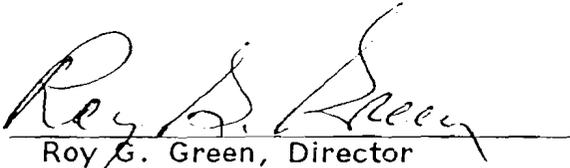
- (1) The applicable rulemaking procedures have been followed; and
- (2) After reviewing and considering data, views and arguments presented at the public hearing and in written testimony, the amendments being adopted are reasonable and proper.

IT IS THEREFORE ORDERED:

- (1) OAR Chapter 436, Division 54, Rules Governing Claims Administration as set forth in Exhibit "A" attached hereto, certified a true copy and hereby made a part of this order, is adopted effective January 1, 1982.
- (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 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 immediately after filing with Secretary of State.

Dated this 23 day of December, 1981.

WORKERS' COMPENSATION DEPARTMENT

  
Roy G. Green, Director

RGG:mh

Distribution: A through AA  
CC, EE and LL

EXHIBIT "A"

OREGON ADMINISTRATIVE RULES  
CHAPTER 436. WORKERS' COMPENSATION DEPARTMENT  
DIVISION 54: CLAIMS ADMINISTRATION

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#### 54-001 AUTHORITY FOR RULES

These rules are promulgated under the Director's authority contained in ORS 656.264, 656.265(6), 656.325 and 656.726(3)(a).

Hist: Filed 12-19-75 as WCB Admin. Order 18-1975, effective 1-1-76  
Amended 4-27-78 as WCD Admin. Order 6-1978, effective 4-27-78  
Amended 1-11-80 as WCD Admin. Order 1-1980, effective 1-11-80

#### 54-003 APPLICABILITY OF RULES

(1) These rules are effective January 1, 1982 to carry out the provisions of:

- (a) ORS 656.210 - Temporary total disability
- (b) ORS 656.212 - Temporary partial disability
- (c) ORS 656.230 - Lump sum payments with Department approval
- (d) ORS 656.245 - Medical services to be provided; choice of doctor
- (e) ORS 656.262 - Responsibility for processing and payment of compensation; sight drafts; acceptance and denial of claim; reporting claims; penalties for payment delays
- (f) ORS 656.268 - Insurer and self-insured employer claim closures
- (g) ORS 656.307 - Determination of issues regarding responsibility for compensation payment
- (h) 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
- (i) ORS 656.726(3) - Department powers and duties generally

(2) These rules supersede:

- (a) WCD Administrative Order 1-1980 adopted January 11, 1980
- (b) WCD Administrative Order 7-1980 adopted October 1, 1980

Hist: Filed 4-27-78 as WCD Admin. Order 6-1978, effective 4-27-78  
Amended 1-11-80 as WCD Admin. Order 1-1980, effective 1-11-80  
Amended 12-23-81 as WCD Admin. Order 6-1981, effective 1-1-82

#### 54-005 DEFINITIONS

(1) "Aggravation" means the worsened condition of an injured worker after the last award or arrangement of compensation, without the intervention of a new injury.

(2) "Attending Physican" means a doctor or physician who is primarily responsible for the treatment of a worker's compensable injury.

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

(4) "Callahan Center" means the William A. Callahan Center, a physical rehabilitation facility of the Workers' Compensation Department located at Wilsonville, Oregon.

(5) "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.

(6) "Compliance Division" means the Compliance Division of the Workers' Compensation Department.

(7) "Continuing benefits" means benefits currently due and being paid which will continue to some future date.

(8) "Department" means the Oregon Workers' Compensation Department, consisting of the Board, Director and all their assistants and employes.

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

(10) "Director" means the Director of the Workers' Compensation Department.

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

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

(13) "Evaluation Division" means the Evaluation Division of the Workers' Compensation Department.

(14) "Future benefits" means the benefits not currently due but which may come due from action on a claim at some later date.

(15) "Insurer" means the State Accident Insurance Fund Corporation or an insurer authorized under ORS Chapter 731 to transact workers' compensation insurer in this state.

(16) "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.

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

(18) "Medical Director" means the Medical Director in the office of the Director of the Workers' Compensation Department.

(19) "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.

(20) "Physical rehabilitation center" means a facility that provides physical rehabilitation and that is either:

(a) The facility operated and controlled by the director and referred to in ORS 656.726(4);

(b) A facility described in ORS 442.015(11) and licensed pursuant to ORS chapter 441, with which the director has contracted for such services pursuant to ORS 656.726(4); or

(c) A facility with which the director has contracted for physical rehabilitation services under ORS 656.726(4) and which employs personnel to provide such physical rehabilitation services who are licensed by a licensing board in the Health Division of the Department of Human Resources.

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

(22) "Self-Insured Employer" means an employer or an employer group who has been certified under ORS 656.430 that [he] the employer meets the qualifications of a self-insured employer set out by ORS 656.407.

(23) "Treating Physician" means attending physician.

Hist: Filed 4-27-78 as WCD Admin. Order 6-1978, effective 4-27-78  
Amended 1-11-80 as WCD Admin. Order 1-1980, effective 1-11-80  
Amended 12-23-81 as WCD Admin. Order 6-1981, effective 1-1-82

#### 54-008 PURPOSE

It is the purpose of the Director that under the provisions of ORS 656.726(3) rules be established to allow insurers and self-insured employers to uniformly process claims. One of the general charges to the Director under the Workers' Compensation Law is the ". . . providing of compensation, regulation and enforcement in connection with . . . ORS 656.001 to 656.794." To meet that responsibility the Director has delegated to the Compliance Division 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 the Compliance Division that an insurer is not processing a claim in accordance with the requirements of the law, the Compliance Division 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, effective 4-27-78  
Amended 1-11-80 as WCD Admin. Order 1-1980, effective 1-11-80

#### 54-010 ADMINISTRATION OF RULES

Any orders issued by the Divisions within the Department 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, effective 4-27-78  
Amended 1-11-80 as WCD Admin. Order 1-1980, effective 1-11-80

#### 54-100 REPORTING REQUIREMENTS

(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 or service company.

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

(3) The insurer or self-insured employer 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 436-827, signed by the worker, is considered written notice of an accident which may involve a compensable injury in accordance with ORS 656.265(2). As such, the signed form 436-827 takes on the authority of the claim form 436-801 and shall be processed the same in accordance with ORS Chapter 656.

(4) Any insurer or self-insured employer 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, effective 1-11-80  
Amended 12-23-81 as WCD Admin. Order 6-1981, effective 1-1-82

#### 54-200 DISABILITY COMPENSATION

#### 54-210 TEMPORARY TOTAL DISABILITY COMPENSATION

#### 54-212 PAYMENT OF TEMPORARY TOTAL DISABILITY COMPENSATION

(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 the insurer with adequate payment documentation, as the insurer may require, to meet these responsibilities.

(2) The rate of compensation for regularly employed workers shall be computed as outlined in ORS 656.210. 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.

(3) The rate of compensation for workers employed with unscheduled, irregular or no earnings shall be computed on the wages determined in the following manner:

(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 use intent at time of hire as confirmed by employer and worker.

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

(c) Employed varying hours, shifts or wages: Use average as in (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 and gratuities are an integral part of earnings: Use wages actually received, plus tips and gratuities, verifiable by employer's records, if available. If not available, use 2 percent of the Oregon average weekly wage at time of injury as defined in ORS 656.211 to determine daily tips and gratuities.

(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 (a). One-half day or more will be considered a full day when determining days worked per week.

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

(k) 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.

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

(m) School teachers: Use annual salary divided by 52 weeks to arrive at weekly wage.

(n) Situation not covered by ORS 656.210 or this section: The employer and worker shall be contacted and a reasonable wage determined to coincide with the objectives of the Workers' Compensation Law.

(4) 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.

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

(6) The period of time during which the worker must be absent from work to keep a medical appointment or have therapy treatment after being released to regular or modified work shall not be considered as loss of earning power as described under ORS 656.212. As such, the worker is not entitled to temporary disability compensation for these visits when the appointment or treatment is scheduled during the work shift.

Hist: Filed 9-21-70 as WCB Admin. Order 12-1970  
Amended 1-11-80 as WCD Admin. Order 1-1980, effective 1-11-80  
Amended 12-23-81 as WCD Admin. Order 6-1981, effective 1-1-82

54-220 TEMPORARY PARTIAL DISABILITY COMPENSATION

54-222 PAYMENT OF TEMPORARY PARTIAL DISABILITY COMPENSATION

(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 (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 or self-insured employer 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 subsection (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 or self-insured employer pursuant to ORS 656.268; or

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

(5) An insurer or self-insured employer shall cease paying temporary total disability compensation and start making payment of such temporary partial disability compensation as would be due in subsection (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; 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 subsection (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 or self-insured employer pursuant to ORS 656.268; or

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

(7) An insurer or self-insured employer shall provide a written explanation to the injured worker 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 the Compliance Division in cases where the worker has refused wage earning employment.

Hist: Filed 4-27-78 as WCD Admin. Order 6-1978, effective 4-27-78  
Amended 1-11-80 as WCD Admin. Order 1-1980, effective 1-11-80  
Amended 12-23-81 as WCD Admin. Order 6-1981, effective 1-1-82

#### 54-230 PERMANENT PARTIAL DISABILITY COMPENSATION

#### 54-232 PAYMENT OF PERMANENT PARTIAL DISABILITY COMPENSATION

(1) When a claim is reopened as a result of an aggravation of the worker's condition and temporary total disability is due, the permanent partial disability payments shall be suspended as of the date of the reopening. Any payments made on the award of permanent partial disability after the medically established date of aggravation shall be reclassified as temporary total disability payments. A lump sum amount shall be paid the worker to adjust for any difference in the rate amounts between permanent partial disability already paid and temporary total disability currently due as a result of reclassifying the benefits. Reclassification of permanent partial disability payment shall not be made when an award has been paid in a lump sum.

(2) Upon termination of temporary total disability payments any permanent disability payments shall be resumed no later than the 30th day after the date of termination, pending a subsequent determination order by the Evaluation Division.

(3) When a training program is authorized in accordance with OAR 436-61 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 or self-insured employer shall suspend any award payments due under the order or mandate and pay time loss.

(4) Upon completion or termination of the authorized training program, any award payments shall be resumed, pending a subsequent determination order by the Evaluation Division, unless the worker's condition is not medically stationary.

Hist: Filed 12-23-81 as WCD Admin. Order 6-1981, effective 1-1-82

#### 54-245 PAYMENT OF MEDICAL SERVICES; CHOICE OF ATTENDING PHYSICIAN

(1) The insurer or self-insured employer shall pay for medical expenses, relating to a compensable injury claim. Such expenses 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 section, 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 an industrial accident the cost is a compensable medical expense, regardless of whether the worker actually received a physical injury at the time of the industrial accident.

(3) Any claim for medical services referred to under ORS 656.245 or this section shall be submitted to the insurer or self-insured employer even after aggravation rights under ORS 656.273 has 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 or self-insured employer 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 or self-insured employer may object to the worker's choice and select the attending physician. Payment for treatment or services rendered to the worker after the insurer or self-insured employer has objected to the worker's choice of attending physician may be rejected by the insurer or self-insured employer.

(6) Subsequent change in attending physician by the worker is limited to four times after the initial choice without approval from the director, unless the insurer or self-insured employer approves of the change. If the insurer or self-insured employer disapproves of an additional change in an attending physician beyond the number permitted, the insurer or self-insured employer may require the director's approval of the change in accordance with OAR 436-69.

Hist: Filed 12-23-81 as WCD Admin. Order 6-1981, effective 1-1-82

#### 54-250 LUMP SUM PAYMENT OF PERMANENT PARTIAL DISABILITY AWARDS

(1) The Compliance Division has the responsibility of approving lump sum payment of permanent partial disability awards in excess of 32 degrees. This responsibility extends to situations where the value of the award, through periodic payments or offsets, is reduced to below the 32 degree value. Any lump sum payment of permanent partial disability award approved through litigation does not require Compliance Division approval.

(2) In cases where the award does not exceed 32 degrees, the insurer or self-insured employer may, in its discretion, pay all or any part of the award to the worker without Compliance Division approval.

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

(4) A worker who has been awarded a permanent partial disability award in excess of 32 degrees may apply to the Compliance Division, through the insurer or self-insured employer, 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) a narrative description of the reason for the lump sum request, with an itemization of any debts owing to be paid by the lump sum amount;

(c) original signatures of both the worker and the insurer or self-insured employer; and

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

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

(6) Compliance Division shall review the circumstances of the worker and the reasons given for the application. If acceptable reasons exist for the request, the application shall be approved when it appears that payment of all or part of the award in a lump sum:

(a) is an appropriate means of carrying out the general purpose of the Workers' Compensation Law to foster the ability of the injured worker to adjust to the worker's new status as a permanently partially disabled worker;

(b) would not jeopardize the future care and support of the worker and the worker's dependents or be likely to cast the worker's future care and support on the citizens of this state; and

(c) would contribute to restoring the injured worker as soon as possible and as near as possible to a condition of self-support and maintenance as an able-bodied worker.

(7) The Compliance Division in considering subsection (5) will not approve a lump sum request when:

(a) the worker is engaged in a training or work experience program;

(b) the worker has been referred for vocational rehabilitation or is temporarily withdrawn from an authorized vocational rehabilitation program; or

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

(8) The Compliance Division 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. The Compliance Division 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.

(9) If the Compliance Division 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.

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

(11) 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 Division. Granting or denying a lump sum is at the sole discretion of the Director. Any such order issued by the Director is not appealable.

(12) If a lump sum payment is approved for part of an award, the remaining balance shall be paid pursuant to ORS 656.216.

(13) Denial or approval of an application under this section 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.

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

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

#### 54-270 REIMBURSEMENT OF RELATED SERVICES COST TO A WORKER

(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 or self-insured employer upon request.

(2) For the purpose of this section:

(a) The actual reasonable cost to a worker of related services resulting from a compensable injury shall be reimbursed within 30 days of the date of receipt by the insurer or self-insured employer 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. Reimbursement in excess of these rates will be allowed in those cases where special transportation or lodging is necessary and required.

(3) Requests for reimbursement of services not claim-related shall be returned to the injured worker within 30 days with an explanation of the reason for nonpayment.

Hist: Filed 10-23-69 as WCB Admin. Order 6-1969, effective 10-29-69  
Amended 1-11-80 as WCD Admin. Order 1-1980, effective 1-11-80  
Amended 12-23-81 as WCD Admin. Order 6-1981, effective 1-1-82

54-280 CONSENT TO SUSPEND COMPENSATION

54-281 CONSENT TO SUSPENSION OF COMPENSATION OR REDUCTION OF BENEFITS AWARDED THE WORKER

(1) The Compliance Division is responsible for issuing an order of consent to the suspension of compensation by an insurer or self-insured employer under the following conditions:

(a) An order shall be issued if the worker, when requested by the Director, insurer or self-insured employer, 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 program at a physical rehabilitation center. 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 Compliance Division may modify or set aside any order of consent to the suspension of compensation authorized before or after a request for hearing is filed.

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

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

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

(6) 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 or self-insured employer, however, such continued payment shall not be recovered at a later date as an overpayment.

(7) The Evaluation Division shall 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 restoration or vocational rehabilitation programs prescribed for the worker pursuant to ORS Chapter 656 and WCD Administrative Rules. The benefits shall 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 restoration or vocational rehabilitation programs.

Hist: Filed 12-11-70 as WCB Admin. Order 16-1970  
Amended 4-27-78 as WCD Admin. Order 6-1978, effective 4-27-78  
Amended 1-11-80 as WCD Admin. Order 1-1980, effective 1-11-80  
Amended 12-23-81 as WCD Admin. Order 6-1981, effective 1-1-82

54-283 REQUEST FOR CONSENT TO SUSPENSION OF COMPENSATION;  
WORKER'S FAILURE OR REFUSAL TO SUBMIT TO MEDICAL EXAMINATION

(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, insurer or self-insured employer. However, no more than three separate medical examinations at different times, excluding examinations by consulting physicians, may be requested during the life of the claim, except after notification to and authorization by the director pursuant OAR 436-69. For the purposes of this section, the Callahan Center shall be presumed to be a place reasonably convenient for an examination of any worker receiving benefits pursuant to ORS Chapter 656.

(2) The Director, insurer or self-insured employer shall notify the worker in writing at least 10 days prior to the examination to ensure receipt of the notice of the following:

(a) purpose of the examination;

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

(c) that the reasonable cost of public transportation or use of a private vehicle will be reimbursed and, that when necessary, reasonable cost of meals, lodging and related services will be reimbursed. 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

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

"ATTENDANCE OF THIS EXAMINATION IS MANDATORY. YOU ARE RESPONSIBLE FOR NOTIFYING US PRIOR TO THE DATE OR TIME OF THE EXAMINATION OF ANY VALID REASON WHY YOU CANNOT ATTEND AS SCHEDULED. FAILURE TO ATTEND THIS EXAMINATION, OBSTRUCTION OF SAME, OR AN INVALID REASON FOR NOT ATTENDING SHALL RESULT IN SUSPENSION OF YOUR COMPENSATION BENEFITS PURSUANT TO ORS 656.325 AND OAR 436-54."

(3) The Director, insurer or self-insured employer 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, insurer or self-insured employer 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.

(4) The Director, insurer or self-insured employer 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.

(5) The insurer or self-insured employer 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 the Compliance Division. 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 436-54;

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

(c) whether the attending physician was consulted to choose a mutually agreeable examining physician;

(d) that the worker failed or refused to be examined and did not advise of any valid reason 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 the Compliance Division.)

(f) the date, time and place of any rescheduled examination; and

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

(6) The Callahan Center when requesting suspension of compensation because of a worker's failure or refusal to attend or cooperate in an examination at the Center shall follow subsection (5).

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

(8) The Compliance Division shall issue an order consenting to the suspension of compensation by an insurer or self-insured employer from a date prescribed in this section and until such time as the worker has submitted to an examination scheduled by the Director, insurer or self-insured employer.

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

"IF YOU THINK THIS ORDER CONSENTING TO THE SUSPENSION OF COMPENSATION IS NOT RIGHT, YOU MAY REQUEST A HEARING BY FILING A LETTER WITH THE HEARINGS DIVISION, WORKERS' COMPENSATION BOARD, 555 13TH STREET N.E., SALEM, OREGON, 97310. YOUR LETTER MUST STATE THAT YOU WANT A HEARING, YOUR ADDRESS AND THE DATE OF YOUR ACCIDENT IF YOU KNOW THE DATE."

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

(11) The insurer or self-insured employer may request an administrative order of closure be issued by the Evaluation Division if the worker has made no effort to have compensation reinstated within 60 days after the Compliance Division 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, effective 4-27-78  
Amended 1-11-80 as WCD Admin. Order 1-1980, effective 1-11-80  
Amended 12-23-81 as WCD Admin. Order 6-1981, effective 1-1-82

54-284 REQUEST FOR CONSENT TO SUSPENSION OF COMPENSATION;  
WORKER'S FAILURE TO PARTICIPATE IN A PROGRAM AT A PHYSICAL  
REHABILITATION CENTER.

(1) A worker is required to participate in a program at a physical rehabilitation center. For the purposes of this section the Callahan Center is considered a physical rehabilitation center. A notice of enrollment issued by a physical rehabilitation center shall include a notice as described in subsection (2) informing the worker that failure to participate in a program at a physical rehabilitation center shall result in suspension of compensation.

(2) The Director, insurer or self-insured employer shall notify the worker in writing at least 10 days prior to the start of a program to ensure receipt of the notice of the following:

- (a) purpose of the program;
- (b) the date, time and place of the program; and
- (c) in prominent or bold-face type the paragraph:

"ATTENDANCE AND PARTICIPATION IS REQUIRED IN A PROGRAM AT A PHYSICAL REHABILITATION CENTER. 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 436-54."

(3) The Director, insurer or self-insured employer upon receipt from the worker of a valid reason for not participating in a program at a physical rehabilitation center 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 subsection (2) will not be required repeated once the worker has agreed to participate in a program at a physical rehabilitation center and then elects to withdraw from the program after the specified date.

(5) The Administrator of the Callahan Center shall act on behalf of the Compliance Division and authorize consent to the suspension of compensation when a worker fails to participate in a program at a physical rehabilitation center. The notice of consent shall contain the following information:

(a) consent to suspension of compensation is being authorized pursuant to ORS 656.325 and OAR 436-54;

(b) what actions of the worker initiated the authorizing of consent to the suspension of compensation;

(c) the period of time the consent to the suspension of compensation is valid;

(d) any pertinent information that supports the consent to the suspension of compensation; and

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

"IF THE WORKER THINKS THIS CONSENT TO THE SUSPENSION OF COMPENSATION IS NOT RIGHT, THE WORKER MAY REQUEST A HEARING BY FILING A LETTER WITH THE HEARINGS DIVISION, WORKERS' COMPENSATION BOARD, 555 13th STREET NE, SALEM, OREGON 97310. THE LETTER MUST STATE THAT A HEARING IS REQUESTED AND INCLUDE THE WORKER'S ADDRESS AND DATE OF INJURY IF KNOWN."

(6) The notice of consent to the suspension of compensation shall be provided by the Administrator of the Callahan Center to the insurer or self-insured employer, the worker, the Compliance Division and any other interested party.

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

(8) The Evaluation Division shall consider a worker's failure to participate in a program at a physical rehabilitation center at the time determination of the worker's claim is made pursuant to ORS 656.268. The Evaluation Division may reduce the benefits awarded by the amount the disability has been increased by the worker's failure to participate in a program at a physical rehabilitation center. Any reduction shall be demonstrated in the Determination Order by a reflection of the amount of disability which would have been awarded and the amount of the award ultimately resulting from the worker's failure to participate in a program at a physical rehabilitation center.

Hist: Filed 12-23-81 as WCD Admin. Order 6-1981, effective 1-1-82

54-285 REQUEST FOR CONSENT TO SUSPENSION OF COMPENSATION;  
WORKER'S COMMISSION OF INSANITARY OR INJURIOUS PRACTICES

(1) The insurer or self-insured employer 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 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 PURSUANT TO ORS 656.325 AND OAR 435-54."

(2) The insurer or self-insured employer 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 or self-insured employer will not be required to repeat the request in subsection (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 or self-insured employer requesting consent to suspension of compensation because of a worker's failure to stop insanitary or injurious practices, shall apply to the Compliance Division. 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 436-54;

(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; and

(e) the date that failure by the worker to stop the practices was verified and with who 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 the Compliance Division.)

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

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

(7) The Compliance Division shall issue an order consenting to the suspension of compensation by an insurer or self-insured employer 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 or self-insured employer and no compensation shall be due or paid during such period.

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

"IF YOU THINK THIS ORDER CONSENTING TO THE SUSPENSION OF COMPENSATION IS NOT RIGHT, YOU MAY REQUEST A HEARING BY FILING A LETTER WITH THE HEARINGS DIVISION, WORKERS' COMPENSATION BOARD, 555 13TH STREET N.E., SALEM, OREGON, 97310. YOUR LETTER MUST STATE THAT YOU WANT A HEARING, YOUR ADDRESS AND THE DATE OF YOUR ACCIDENT IF YOU KNOW THE DATE."

(9) The insurer or self-insured employer 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 or self-insured employer shall immediately notify the Compliance Division by letter of the date of resumption.

(10) The insurer or self-insured employer may request an administrative order of closure be issued by the Evaluation Division if the worker has made no effort to have compensation reinstated within 60 days after the Compliance Division 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, effective 4-27-78  
Amended 1-11-80 as WCD Admin. Order 1-1980, effective 1-11-80  
Amended 12-23-81 as WCD Admin. Order 6-1981, effective 1-1-82

54-286 REQUEST FOR CONSENT TO SUSPENSION OF COMPENSATION;  
WORKER'S REFUSAL TO SUBMIT TO MEDICAL OR SURGICAL TREATMENT;  
EVALUATION DIVISION REDUCTION OF PERMANENT PARTIAL DISABILITY  
AWARDED

(1) The insurer or self-insured employer shall upon knowledge of a 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 shall explain:

- (a) the need for the recommended medical or surgical treatment;
- (b) that such treatment is considered essential by the attending physician to promote the worker's recovery;
- (c) that consent for such treatment be given to the attending physician 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 ESSENTIAL BY THE ATTENDING PHYSICIAN 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 436-54."

(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 or self-insured employer 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 attending physician. 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.

(4) The insurer or self-insured employer shall verify on the specified date whether the worker did or did not give consent to the attending physician for the recommended medical or surgical treatment.

(5) The insurer or self-insured employer will not be required to repeat the request in subsection (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.

(6) The insurer or self-insured employer requesting consent to suspension of compensation because of a worker's refusal to submit to recommended medical or surgical treatment, shall apply to the Compliance Division. 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 436-54;

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

(c) whether or not the attending physician considers the treatment 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; and

(f) the date that failure by the worker to give consent for the treatment was verified and with who 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 the Compliance Division, or not at all.)

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

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

(9) The Compliance Division shall issue an order consenting to the suspension of compensation by an insurer or self-insured employer for any period of time during which a worker refuses to submit to recommended medical or surgical treatment 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.

(10) The insurer or self-insured 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 or self-insured employer shall immediately notify the Compliance Division by letter of the date of resumption.

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

(12) The Compliance Division shall issue an order consenting to the suspension of compensation by an insurer or self-insured employer from the date of administrative discharge from the Callahan Center and until the worker has again reenrolled for services.

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

"IF YOU THINK THIS ORDER CONSENTING TO THE SUSPENSION OF COMPENSATION IS NOT RIGHT, YOU MAY REQUEST A HEARING BY FILING A LETTER WITH THE HEARINGS DIVISION, WORKERS' COMPENSATION BOARD, 555 13TH STREET N.E., SALEM, OREGON 97310. YOUR LETTER MUST STATE THAT YOU WANT A HEARING, YOUR ADDRESS AND THE DATE OF YOUR ACCIDENT IF YOU KNOW THE DATE."

(14) When the suspension is not approved, the Compliance Division shall notify the insurer or self-insured employer of the reason for denial.

(15) The Evaluation Division shall consider a worker's refusal to submit to such medical or surgical treatment as is reasonably essential to promote recovery at the time determination of the worker's claim is made pursuant to ORS 656.268. The Evaluation Division may reduce the benefits awarded by the amount the disability has been increased by the worker's refusal to submit to such medical or surgical treatment. Any reduction shall be demonstrated in the Determination Order by a reflection of the amount of disability which would have been awarded and the amount of the award ultimately resulting from the worker's failure to submit to such treatment.

Hist: Filed 12-11-70 as WCB Admin. Order 16-1970  
Amended 4-27-78 as WCD Admin. Order 6-1978, effective 4-27-78  
Amended 1-11-80 as WCD Admin. Order 1-1980, effective 1-11-80  
Amended 12-23-81 as WCD Admin. Order 6-1981, effective 1-1-82

54-287 PETITION FOR REDUCTION OF BENEFITS; WORKER'S FAILURE TO FOLLOW MEDICAL ADVICE OR PARTICIPATE IN OR COMPLETE PHYSICAL RESTORATION OR VOCATIONAL REHABILITATION PROGRAMS

(1) The Director, insurer or self-insured employer which determines that a worker has failed to follow the medical advice of the attending physician 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 the Evaluation Division.

(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 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) The Evaluation Division 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 the Evaluation Division that the worker has failed to follow the medical advice of the attending physician or has failed to participate in or complete physical restoration or vocational rehabilitation programs. The Evaluation Division, if necessary, may require other information from the insurer to adequately demonstrate the worker's 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) The Evaluation Division 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 (1) above or under the provisions of (2) above, reduce the benefits awarded by the amount the disability has been increased by the worker's 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.

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Amended 1-11-80 as WCD Admin. Order 1-1980, effective 1-11-80  
Amended 12-23-81 as WCD Admin. Order 6-1981, effective 1-1-82

#### 54-300 CLAIM RESPONSIBILITY OF INSURERS AND SELF-INSURED EMPLOYERS

#### 54-305 ACCEPTANCE OR DENIAL OF A CLAIM

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

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

(3) The notice of acceptance in compliance with ORS 656.262 and OAR 436-83 shall:

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

(b) inform the worker 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 under ORS Chapter 659;

(d) inform the worker of assistance available to employers for job site modification, as provided in OAR 436-63; 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 or self-insured employer 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 OAR 436-83 shall:

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

(b) inform the worker of hearing rights.

(5) The insurer or self-insured employer shall send notice of the denial to each provider of medical services 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 or self-insured employer 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 or self-insured employer shall or the employer may make payment of compensation due pursuant 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 the Compliance Division 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, effective 1-11-80  
Amended 12-23-81 as WCD Admin. Order 6-1981, effective 1-1-82

#### 54-310 TIMELY PAYMENT OF COMPENSATION

(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, insurer or self-insured employer 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 an insurer and 90% for a self-insured employer. An insurer or self-insured employer 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 injury 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) authorized vocational rehabilitation start date or the date of the authorization letter, whichever is later, 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 litigation order which orders temporary disability; or

(f) date a noncomplying employer claim has been referred by the Workers' Compensation Department to the State Accident Insurance Fund.

(4) Continued temporary disability due should be paid current to date of payment at least once each 14 days thereafter, but in no event shall benefits due be more than one week in arrears. The employer, when making payments as provided in 54-212(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 Workers' Compensation Department; or

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

(6) Subsequent payments of permanent disability benefits are made in monthly sequence. Adjustments to monthly payment dates may be made by the insurer or self-insured employer, 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 45 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 or self-insured employer will pay the undisputed amount. Resolution of the disputed amount will be made in accordance with OAR 436-69.

(8) The insurer or self-insured employer 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.

Hist: Filed 11-14-66 as WCB Admin. Order 9-1966  
Amended 1-11-80 as WCD Admin. Order 1-1980, effective 1-11-80  
Amended 12-23-81 as WCD Admin. Order 6-1981, effective 1-1-82

#### 54-315 USE OF SIGHT DRAFT TO PAY COMPENSATION PROHIBITED

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, effective 1-1-76  
Amended 4-27-78 as WCD Admin. Order 6-1978, effective 4-27-78  
Amended 1-11-80 as WCD Admin. Order 1-1980, effective 1-11-80

#### 54-320 RECOVERY OF OVERPAYMENT OF BENEFITS

Insurers and self-insured employers may recover overpayment of benefits paid to a worker on an accepted claim from benefits which are or may become payable on that claim. Payment of benefits paid prior to denial pursuant to ORS 656.262(5) or paid during appeal pursuant to ORS 656.313 shall not be recoverable under this section.

(1) Overpayments may be recovered by:

(a) reduction of continuing temporary disability benefits in an amount not to exceed 25 percent of the benefit without prior authorization from the worker or beneficiary;

(b) withholding reimbursement of related services to the worker; or

(c) adjustment in compensation benefits determined due pursuant to ORS 656.268, to include permanent partial disability, permanent total disability and fatal disability benefits. Recovery of overpayment from a permanent partial disability award may result in partial or total offset against the award. Recovery from a permanent total disability or fatal award shall be made as in (a) above.

(2) Recovery of overpayment by the insurer or self-insured employer shall be explained in written form to the worker, 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.

(3) Overpayments may not be recovered by withholding payments to the providers of services or from reimbursable temporary disability paid during an approved vocational rehabilitation program.

Hist: Filed 1-11-80 as WCD Admin. Order 1-1980, effective 1-11-80  
Amended 12-23-81 as WCD Admin. Order 6-1981, effective 1-1-82

#### 54-330 DESIGNATION OF A PAYING AGENT

#### 54-332 DESIGNATION AND RESPONSIBILITY OF A PAYING AGENT

(1) For the purpose of this section:

(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) The Compliance Division shall, by order, designate who shall pay a claim, if 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) Insurers or self-insured employers with knowledge of a situation as defined in subsection (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.

(4) When a situation as described in subsection (2) arises, the insurers or self-insured employers shall immediately notify any other affected insurers or self-insured employers of the situation. A copy of all medical reports or other pertinent material available relative to the injury shall be provided the other parties.

(5) Such notice received from another insurer of self-insured employer shall be notice of a claim referred by the Director as provided by ORS 656.265(3).

(6) Upon determining an issue exists as to the responsibility for an otherwise compensable injury, an insurer or self-insured employer shall request a paying agent be designated by application in letter form to the Compliance Division. The application shall be addressed to the attention of the Claims Supervisor and contain the following information:

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

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

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

(7) The Compliance Division 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 Department or Board.

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

(9) The Compliance Division, 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 of self-insured employers involved.

(10) Insurers or self-insured employers receiving notice from the Department of a worker's request for designation of a paying agent shall immediately process the request in accordance with subsections (3) through (6) of this section.

(11) The Compliance Division, upon receipt of written acknowledgement from the insurers or self-insured employers 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 or self-insured employer 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 the Compliance Division order.

(12) The Compliance Division, by copy of its order, shall refer the matter to the Hearings Division of the Workers' Compensation Board to set a hearing pursuant to ORS 656.307 to determine the issue of responsibility of benefits to the worker.

(13) The designated paying agent shall process the claim as an accepted claim through determination unless relieved of the responsibility by a hearing order.

Hist: Filed 1-11-80 as WCD Admin. Order 1-1980, effective 1-11-80  
Amended 4-29-80 as WCD Admin. Order 5-1980, effective 4-29-80  
(Temp.)  
Amended 10-1-80 as WCD Admin. Order 7-1980, effective 10-1-80

#### 54-334 MONETARY ADJUSTMENTS AMONG PARTIES AND WORKERS' COMPENSATION DEPARTMENT

(1) When all litigation on the issue of responsibility is final, and the responsible paying party has been determined, the Compliance Division 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 or self-insured employer shall be recovered from the Administrative Fund.

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

(3) When the compensability of a claim becomes an issue subsequent to the designation of a paying agent, the Compliance Division 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 hearing 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 hearing shall preclude the designated paying agent from recovering from the Administrative Fund.

Hist: Filed 6-3-70 as WCB Admin. Order 5-1970  
Amended 1-11-80 as WCD Admin. Order 1-1980, effective 1-11-80  
Amended 4-29-80 as WCD Admin. Order 5-1980, effective 4-29-80  
(Temp.)  
Amended 10-1-80 as WCD Admin. Order 7-1980, effective 10-1-80  
Amended 12-23-81 as WCD Admin. Order 6-1981, effective 1-1-82

#### 54-980 PENALTIES

#### 54-981 ASSESSMENT OF CIVIL PENALTIES

(1) The Director through the Compliance Division and pursuant to ORS 656.745 may assess a civil penalty against an employer, insurer or self-insured employer.

(2) An employer, insurer or self-insured employer may be assessed a civil penalty up to \$1,000 for violation of Oregon Administrative Rules 54-100, 54-250, 54-270, 54-305, 54-310 and 54-332.

(3) An insurer or self-insured employer in violation of Oregon Administrative Rule 54-315 shall be assessed a civil penalty of \$1,000.

(4) Notwithstanding subsection (2) of this section, an insurer or self-insured employer 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.

(5) For the purpose of subsection (4), statutory claims processing requirements would include but not be limited to, 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, and ORS 656.330.

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

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

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

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

(7) When a penalty, based upon ratios, is appropriate and the volume to which the volume of errors are compared is 10 or less, the Compliance Division shall assess no more than \$200 regardless of the percentage of error. When, however, the volume exceeds 10 the Compliance Division 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, effective 1-11-80  
Amended 12-23-81 as WCD Admin. Order 6-1981, effective 1-1-82

#### 54-983 ISSUANCE/SERVICE OF PENALTY ORDERS

(1) When a penalty is assessed as provided by 54-981, the Compliance Division 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, the Compliance Division shall furnish the Department of Justice with pertinent records in the matter as requested.

(2) The Compliance Division shall serve the Order:

(a) by delivering a copy of the Order to the party in the manner provided by ORS 15.080; 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, effective 1-11-80

#### 54-998 ADMINISTRATIVE REVIEW

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.

Hist: Filed 4-27-78 as WCD Admin. Order 6-1978, effective 4-27-78  
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