

FILED
DEC 29 1983
NORMA PAULUS
SECRETARY OF STATE

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

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

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

On October 5, 1983, 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 in accordance with ORS 171.707.

Copies of the notice were mailed to interested persons in accordance with ORS 183.335(7) and 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, 1983, Secretary of State's Administrative Rule Bulletin.

On November 3, 1983, the public hearing was held as announced. A summary of the written testimony and agency responses thereto is contained in Exhibit "C." This summary is on file and available for public inspection between the hours of 8 a.m. and 5 p.m., normal working days Monday through Friday in the Directors' Office, Workers' Compensation Department, Room 201, Labor & Industries Bldg, Salem, Oregon 97310.

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

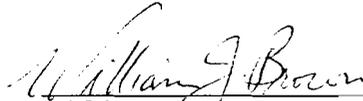
- a. The applicable rule making procedures have been followed.
- b. The rules are within the director's authority.
- c. The rules being adopted are a reasonable administrative interpretation of the statutes and are required to carry out statutory responsibilities.

IT IS THEREFORE ORDERED THAT:

- (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 part of this order, is adopted effective January 1, 1984.
- (2) A certified true copy of the Order of Adoption and these rules, with Exhibit "B" consisting of the Citation of Statutory Authority, Statement of Need, Documents Relied on and Fiscal Impact Statement, attached hereto and hereby made a part of this order, be filed with the Secretary of State.
- (3) A copy of the rules and attached Exhibit "B" be filed with the Legislative Counsel pursuant to the provisions of ORS 183.75 within ten days after filing with the Secretary of State.

Dated this 29th day of December, 1983.

WORKERS' COMPENSATION DEPARTMENT



William J. Brown, Director

Distribution: A through AA;
Plus CC, DD, EE and LL

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).

Hist: Filed 12-19-75 as WCB Admin. Order 18-1975, eff. 1-1-76
Amended 4-27-78 as WCD Admin. Order 6-1978, eff. 4-27-78
Amended 1-11-80 as WCD Admin. Order 1-1980, eff. 1-11-80
Amended 12-29-83 as WCD Admin. Order 8-1983, eff. 1-1-84

54-003 APPLICABILITY OF RULES

(1) These rules are effective January 1, 1984, 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 656.264 - Compensable injury, claim and other reports
 - (g) ORS 656.265 - Notice of accident from worker
 - (h) ORS 656.268 - Insurer and self-insured employer claim closures
 - (i) ORS 656.307 - Determination of issues regarding responsibility for compensation payment
 - (j) 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
 - (k) ORS 656.726(3) - Department powers and duties generally
- (2) These rules supersede:
- (a) WCD Administrative Order 6-1981 adopted December 23, 1981.

Hist: Filed 4-27-78 as WCD Admin. Order 6-1978, eff. 4-27-78
Amended 1-11-80 as WCD Admin. Order 1-1980, eff. 1-11-80
Amended 12-23-81 as WCD Admin. Order 6-1981, eff. 1-1-82
Amended 12-29-83 as WCD Admin. Order 8-1983, eff. 1-1-84

54-005 DEFINITIONS

For the purpose of these rules unless the context requires otherwise:

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

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

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

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

(17) "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.

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

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

(20) "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.

(21) "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) The 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.

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

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

Hist: Filed 4-27-78 as WCD Admin. Order 6-1978, eff. 4-27-78
Amended 1-11-80 as WCD Admin. Order 1-1980, eff. 1-11-80
Amended 12-23-81 as WCD Admin. Order 6-1981, eff. 1-1-82
Amended 12-29-83 as WCD Admin. Order 8-1983, eff. 1-1-84

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 that ". . . 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, eff. 4-27-78
Amended 1-11-80 as WCD Admin. Order 1-1980, eff. 1-11-80
Amended 12-29-83 as WCD Admin. Order 8-1983, eff. 1-1-84

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, eff. 4-27-78
Amended 1-11-80 as WCD Admin. Order 1-1980, eff. 1-11-80
Amended 12-29-83 as WCD Admin. Order 8-1983, eff. 1-1-84

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

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

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

(5) 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 shall start the claim process the same as the Form 436-801, but shall not relieve the worker or employer of the responsibility of filing the Form 436-801.

(6) 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.

(7) The insurer or self-insured employer is not required to, but may in its discretion, issue a "Notice of Closure" pursuant to ORS 656.268(3) on a claim that is determined nondisabling, but without either temporary or permanent disability, as long as the worker has been informed in writing of substantially the following:

(a) the claim is called a "nondisabling injury" for the reason no compensable time loss from work is due and no permanent disability exists as a result of the injury;

(b) the right to request a reclassification by the Workers' Compensation Department within one year after the date of injury;

(c) the right to file a claim for aggravation within five years after the date of injury; and

(d) any other information as the director may require.

Hist: Filed 1-11-80 as WCD Admin. Order 1-1980, eff. 1-11-80
Amended 12-23-81 as WCD Admin. Order 6-1981, eff. 1-1-82
Amended 12-29-83 as WCD Admin. Order 8-1983, eff. 1-1-84

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 or self-insured administrator with adequate payment documentation, as the insurer or self-insured administrator may require, to meet these responsibilities.

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

(3) 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. Any workers' compensation benefits shall be identified separate from other moneys paid by the employer and shall not have usual payroll deductions withheld from such benefits.

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

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

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

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

(n) School teachers: Use annual salary divided by 52 weeks to arrive at weekly wage. Statutory temporary disability benefits shall extend over the calendar year and not just the nine-month school year.

(o) 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.

(5) 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.

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

(7) 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, eff. 1-11-80
Amended 12-23-81 as WCD Admin. Order 6-1981, eff. 1-1-82
Amended 12-29-83 as WCD Admin. Order 8-1983, eff. 1-1-84

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 section (3) shall continue to be paid until:

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

(b) the compensation is terminated by order of the Department or by claim closure by the insurer 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 section (1) when an injured worker refuses wage earning employment prior to claim determination under the following conditions:

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

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

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

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

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

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

(c) the compensation is terminated by order of the Department or by claim closure of the insurer 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, eff. 4-27-80
Amended 1-11-80 as WCD Admin Order 1-1980, eff. 1-11-80
Amended 12-23-81 as WCD Admin. Order 6-1981, eff. 1-1-82
Amended 12-29-83 as WCD Admin. Order 8-1983, eff. 1-1-84

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 training commences 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 training, any award payments shall be resumed. If no award payment remains due, temporary disability shall continue pending a subsequent determination order by the Evaluation Division, unless the worker has returned to regular employment.

Hist: Filed 12-23-81 as WCD Admin. Order 6-1981, eff. 1-1-82
Amended 12-29-83 as WCD Admin. Order 8-1983, eff. 1-1-84

54-245 PAYMENT OF MEDICAL SERVICES: CHOICE OF ATTENDING PHYSICIAN

(1) Only 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 rule shall be submitted to the insurer or self-insured employer even after aggravation rights under ORS 656.273 have expired. If the claim for medical services is denied, the worker may submit a request for hearing pursuant to ORS 656.283.

(4) The worker may choose an attending physician within the state of Oregon. Reimbursement to the worker of transportation costs to visit the attending physician, however, may be limited to within a city, or metropolitan area, or the distance to the nearest city or metropolitan area, from where the worker resides and where a physician providing like services is available. A worker who relocates within the state of Oregon may continue treating with the attending physician and be reimbursed transportation costs accordingly. If an insurer 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 of 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, eff. 1-1-82
Amended 12-29-83 as WCD Admin. Order 8-1983, eff. 1-1-84

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 64 degrees. This responsibility extends to situations where the value of the award, through periodic payments or offset, is reduced to below the 64 degree value. Any lump sum payment of permanent partial disability award approved through litigation does not require Compliance Division approval.

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

(3) In cases where the final payment would be less than the amount computed in accordance with ORS 656.216(1), the insurer 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 64 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 ALL OR ANY PART 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. 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 an application will not approve a lump sum payment 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 lump sum payment shall be in addition to the regularly scheduled monthly payment. The remaining balance shall be paid pursuant to ORS 656.216.

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

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

Hist: Filed 6-23-66 as WCB Admin. Order 6-1966
Amended 2-13-74 as WCB Admin. Order 5-1974, eff. 3-11-74
Amended 1-11-80 as WCD Admin. Order 1-1980, eff. 1-11-80
Amended 12-23-81 as WCD Admin. Order 6-1981, eff. 1-1-82
Amended 12-29-83 as WCD Admin. Order 8-1983, eff. 1-1-84

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 60 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 employees 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 60 days of the date of receipt by the insurer or self-insured employer with an explanation of the reason for nonpayment.

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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 worker shall be provided the opportunity to dispute the matter of suspension of compensation prior to the issuance of an order by the Compliance Division.

(3) 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.

(4) 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.

(5) 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.

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

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

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

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

(3) 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) name of the examining physician or facility;
- (b) the purpose of the examination;
- (c) the date, time and place of the examination;
- (d) the attending physician was notified of the examination;
- (e) when required, the medical director has approved the examination;
- (f) that the reasonable cost of public transportation or use of a private vehicle will be reimbursed and, that when necessary, reasonable cost of 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
- (g) in prominent or bold-face type the paragraph:

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

(4) 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.

(5) 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.

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

(d) that the worker failed or refused to be examined and any reason given by the worker why the examination could not be attended as scheduled. If a reason was provided by 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) whether an examination will be rescheduled and, if so, the date, time and place of any rescheduled examination;

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

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

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

(7) The application to the Compliance Division shall be accompanied by a copy of the letter required in section (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 IS NOT RIGHT YOU MAY REQUEST A RECONSIDERATION OR A HEARING. REQUEST FOR RECONSIDERATION MUST BE IN WRITING AND SENT TO THE COMPLIANCE DIVISION, WORKERS' COMPENSATION DEPARTMENT, LABOR & INDUSTRIES BLDG., SALEM, OR 97310. HEARINGS REQUESTS MUST BE SENT TO THE HEARINGS DIVISION, WORKERS' COMPENSATION BOARD, 480 CHURCH STREET SE, SALEM, OR 97310."

(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.

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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 section (3) informing the worker that failure to participate in a program at a physical rehabilitation center shall result in suspension of compensation.

(2) Notice of the pending suspension of compensation shall be given the worker to provide the opportunity to dispute such action.

(3) 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."

(4) 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.

(5) The notice in section (3) 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.

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

(7) 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.

(8) 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.

(9) 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 the 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.

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54-285 REQUEST FOR CONSENT TO SUSPENSION OF COMPENSATION;
WORKER'S COMMISSION OF INSANITARY OR INJURIOUS PRACTICES; EVALUATION
DIVISION REDUCTION OF PERMANENT PARTIAL DISABILITY AWARDED

(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 AND POSSIBLE REDUCTION OF ANY PERMANENT DISABILITY AWARDED PURSUANT TO ORS 656.325 AND OAR 436-54."

(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 section (1) once the injured worker has been put on notice and again commits the same insanitary or injurious practices after the specified date.

(4) The insurer 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, with copy to the worker, 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;

(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; and

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

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

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

(6) The Compliance Division shall consult with the Medical Director to review whether the practices are 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 IS NOT RIGHT YOU MAY REQUEST A RECONSIDERATION OR A HEARING. REQUEST FOR RECONSIDERATION MUST BE IN WRITING AND SENT TO THE COMPLIANCE DIVISION, WORKERS' COMPENSATION DEPARTMENT, LABOR & INDUSTRIES BLDG., SALEM, OR 97310. HEARINGS REQUESTS MUST BE SENT TO THE HEARINGS DIVISION, WORKERS' COMPENSATION BOARD, 480 CHURCH STREET SE, SALEM, OR 97310."

(9) The insurer 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.

(11) The Evaluation Division shall consider a worker's commission of an insanitary or injurious practice which hinders recovery, whether committed once or several times, 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 insanitary or injurious practice. 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 commission of the insanitary or injurious practice.

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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 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 reasonably essential to promote the worker's recovery;

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

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

"THE DECISION WHETHER TO RECEIVE MEDICAL OR SURGICAL TREATMENT CONSIDERED REASONABLY ESSENTIAL TO PROMOTE RECOVERY IS A DECISION OF THE INJURED WORKER. FAILURE, HOWEVER, TO GIVE CONSENT BY THE DATE INDICATED OR FAILURE TO ACTUALLY RECEIVE SUCH TREATMENT SHALL RESULT IN SUSPENSION OF YOUR COMPENSATION BENEFITS AND POSSIBLE REDUCTION OF ANY PERMANENT DISABILITY AWARDED PURSUANT TO ORS 656.325 and OAR 436-54."

(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 verify on the specified date whether the worker did or did not give consent for the recommended medical or surgical treatment.

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

(5) The insurer 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, with copy to the worker, 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 reasonably essential to promote the worker's recovery;

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

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

(f) the date that failure by the worker to give consent for the treatment was verified and with 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; and

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

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

(6) The insurer 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 physician recommending such treatment. Documentation should consist of doctor's reports, copies of correspondence, reports of consultation on the medical or surgical treatment recommended or any other written evidence which demonstrates the recommended treatment is reasonably essential.

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

(8) The Compliance Division shall consult with the Medical Director to review whether the recommended treatment is reasonably 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 reasonably essential to promote recovery. The consent to suspension of compensation shall continue until the date the worker has, in fact, consented to the recommended medical or surgical treatment and no compensation shall be due or paid during such period. When the worker has established a pattern of noncooperation, the Compliance Division may require the worker to begin recommended treatment before compensation shall be restarted.

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

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

(14) 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.

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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 OR COMMISSION OF INSANITARY OR INJURIOUS PRACTICES

(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 committed an insanitary or injurious practice or has failed to participate in or complete physical restoration or vocational rehabilitation programs may petition for a reduction of benefits awarded the worker when determination is made pursuant to ORS 656.268.

(a) The petition for reduction of benefits will be sent to 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 commission of an insanitary or injurious practice or failure to follow the attending physician's medical advice or participate in or complete physical restoration or vocational rehabilitation programs. Documentation may consist of telephone memoranda, doctor's reports, copies of correspondence, investigative reports or any other written evidence of the worker's failure to cooperate.

(2) 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 committed an insanitary or injurious practice or failed to follow the medical advice of the attending physician or has failed to participate in or complete physical restoration or vocational rehabilitation programs. The Evaluation Division, if necessary, may require other information from the insurer to adequately demonstrate the worker's commission of an insanitary or injurious practice or failure to follow the attending physician's medical advice or participate in or complete physical restoration or vocational rehabilitation programs prescribed for the worker pursuant to ORS Chapter 656 and WCD Administrative Rules.

(3) 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 commission of an insanitary or injurious practice or failure to follow medical advice from his attending physician or to participate in or complete physical restoration or vocational rehabilitation programs. Any reduction shall be demonstrated in the Determination Order by the amount of disability which would have been awarded and the amount of the award ultimately resulting from the worker's failure to cooperate.

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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 reported claims during any quarter may receive a penalty assessed by the director.

(3) The notice of acceptance in compliance with ORS 656.262 and 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 and health insurance when compensability of all, or any portion, of a claim for medical services is denied. When the compensability issue has been finally determined the insurer 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, eff. 1-11-80
Amended 12-23-81 as WCD Admin. Order 6-1981, eff. 1-1-82
Amended 12-29-83 as WCD Admin. Order 8-1983, eff. 1-1-84

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 claim if temporary disability is immediate and payable;

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

(c) 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 determination or litigation order which orders temporary disability;

(f) date a claim has been referred by the Workers' Compensation Department to the insurer or self-insured employer for processing pursuant ORS 656.029; or

(g) 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 as earned. 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 60 days of the receipt of statement. When there is a dispute over the amount of a bill or the necessity of

services rendered, the insurer 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, eff. 1-11-80
Amended 12-23-81 as WCD Admin. Order 6-1981, eff. 1-1-82
Amended 12-29-83 as WCD Admin. Order 8-1983, eff. 1-1-84

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, eff. 1-1-76
Amended 4-27-78 as WCD Admin. Order 6-1978, eff. 4-27-78
Amended 1-11-80 as WCD Admin. Order 1-1980, eff. 1-11-80
Amended 12-29-83 as WCD Admin. Order 8-1983, eff. 1-1-84

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(6) 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, eff. 1-11-80
Amended 12-23-81 as WCD Admin. Order 6-1981, eff. 1-1-82
Amended 12-29-83 as WCD Admin. Order 8-1983, eff. 1-1-84

54-330 DESIGNATION OF A PAYING AGENT

54-332 DESIGNATION AND RESPONSIBILITY OF A PAYING AGENT

(1) For the purpose of this rule:

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

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

(2) 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) Own Motion claims are exempt from the provisions of this rule.

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

(5) When a situation as described in section (2) is identified, the insurers 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 with the notification.

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

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

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

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

(c) responsibility is an issue;

(d) identification of all parties and claims involved;

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

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

(8) 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.

(9) 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.

(10) 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 insurer or self-insured employer involved.

(11) Insurer 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 sections (3) through (7).

(12) The Compliance Division, upon receipt of written acknowledgment 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. When a situation arises under ORS 656.029 as to who is the true employer of a worker at the time of accident, the person letting the contract shall be deemed the employer and the employer or its insurer 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.

(13) 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.

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

Hist: Filed 1-11-80 as WCD Admin. Order 1-1980, eff. 1-11-80
Amended 4-29-80 as WCD Admin. Order 5-1980, eff. 4-29-80
(Temp.)
Amended 10-1-80 as WCD Admin. Order 7-1980, eff. 10-1-80
Amended 12-29-83 as WCD Admin. Order 8-1983, eff. 1-1-84

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

(1) An order pursuant ORS 656.307 and OAR 436-54-332 shall apply only to the period prior to the order of a referee determining the responsible paying party. Payment of compensation made thereafter shall not be recovered from the Administrative Fund, except where the Director concludes payment was made after the date of the order of the referee, but before the order was received by the paying agent designated under OAR 436-54-332.

(2) 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 for compensation paid as a result of an order pursuant OAR 436-54-332 shall be recovered from the Administrative Fund.

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

(4) 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, eff. 1-11-80
Amended 4-29-80 as WCD Admin. Order 5-1980, eff. 4-29-80
(Temp.)
Amended 10-1-80 as WCD Admin. Order 7-1980, eff. 10-1-80
Amended 12-23-81 as WCD Admin. Order 6-1981, eff. 1-1-82
Amended 12-29-83 as WCD Admin. Order 8-1983, eff. 1-1-84

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 who willfully violates Oregon Administrative Rule 54-315 shall be assessed a civil penalty of \$1,000.

(4) Notwithstanding section (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 section (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 reported, or

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

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

(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, eff. 1-11-80
Amended 12-23-81 as WCD Admin. Order 6-1981, eff. 1-1-82
Amended 12-29-83 as WCD Admin. Order 8-1983, eff. 1-1-84

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 ORCP 7D.(3); or

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

Hist: Filed 1-11-80 as WCD Admin. Order 1-1980, eff. 1-11-80
Amended 12-29-83 as WCD Admin. Order 8-1983, eff. 1-1-84

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: File 4-27-78 as WCD Admin. Order 6-19-78, eff. 4-27-78
Amended 1-11-80 as WCD Admin. Order 1-1980, eff. 1-11-80
Amended 12-29-83 as WCD Admin. Order 8-1983, eff. 1-1-84

EXHIBIT "B"

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

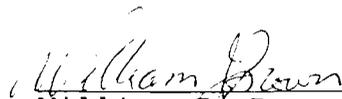
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|-----------------------------------|---|-------------------------------|
| In the Matter of the Amendment |) | Statutory Authority, |
| of Rules Governing Claims |) | Statement of Need, |
| Administration (OAR Chapter 436, |) | Principal Documents Relied |
| Workers' Compensation Department, |) | Upon, and Statement of Fiscal |
| Division 54). |) | Impact |

1. Citation of Statutory Authority The Statutory Authority for promulgation of these rules is ORS 656.264, 656.265(6), 656.325 and 656.726(3)(a).
2. Need for Rules The need for such rules is to govern the provisions of claims administration in accordance with existing law and statutory amendments passed by the 1983 Legislature.
3. Principal Documents Relied Upon The commands of the statutes above referenced to create the need for these rules. No other principal documents, reports, or studies were relied upon.
4. Fiscal and Economic Impact The following entities are economically affected: (a) state agencies, in their role of employer; (b) units of local government, in their role of employer; (c) large and small private sector employers subject to the Workers' Compensation Law; (d) insurance companies processing workers' compensation claims; and (e) State Accident Insurance Fund, in the role of insurer.

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

Dated this 29th day of December, 1983.

WORKERS' COMPENSATION DEPARTMENT



 William J. Brown, Director

EXHIBIT "C"
BEFORE THE DIRECTOR OF THE
WORKERS' COMPENSATION DEPARTMENT
OF THE STATE OF OREGON

| | |
|--|------------------|
| In the Matter of the Amendment of OAR) | SUMMARY OF THE |
| Chapter 436, Workers' Compensation) | TESTIMONY AND |
| Department, Division 54, Rules Govern-) | AGENCY RESPONSES |
| ing Claims Administration.) | |

This document relates to the Order of Adoption, WCD Administrative Order 8-1983, in the above-referenced matter. It constitutes and contains a summary of the significant data, views, and arguments contained in the hearing record. It includes data submitted in accordance with the announcement that additional material could be submitted until November 14, 1983.

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

The amendment of the rules was announced in the Secretary of State Administrative Rules Bulletin dated October 15, 1983. A public hearing was held on November 3, 1983. The hearing was subsequently adjourned until November 14, 1983, to receive additional written testimony. During the hearing and during the intervening period, interested persons presented written statements, arguments, and recommendations in regard to the proposed rules. The major issues raised were:

TESTIMONY: Section (1) of 54-005, the definition "aggravation" should be reworded or the term "worsened condition" be defined to clarify its meaning.

RESPONSE: The definition of "aggravation" is reworded to reflect the concern and intent of the testimony.

TESTIMONY: Section (2) of 54-005, the definition "attending physician" should be redefined to include the wording ". . . accepts the primary responsibility . . ." to better identify the attending physician.

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

TESTIMONY: A new section (15) of 54-005, the definition "health insurance" should be added to reflect the meaning of the term provided in ORS 731.162 of the insurance code.

RESPONSE: The definition of "health insurance" found under ORS 731.162 is added to the rules to reflect the concern and intent of the testimony.

TESTIMONY: Section (23) of 54-005, the definition "treating physician" should be eliminated as no purpose is served by having two terms to define the same party.

RESPONSE: The definition is deleted to reflect the concern and intent of the testimony as the term has been eliminated from Chapter 656 and OAR 436-54.

TESTIMONY: A new section should be added to 54-100 clarifying that insurers' "Notice of Closure" are not required on all nondisabling or medical only claims. It was legislative intent when the current ORS 656.268(3) was adopted to ease the administrative burden on the department and to facilitate prompt closure of time loss claims without permanent disability. To interpret otherwise would impose an enormous and unnecessary burden on the workers' compensation system.

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

TESTIMONY: Section (1) of 54-100 should be amended to require the employer to report a claim within 72 hours as is required of the provider in 69-101.

RESPONSE: The statute in 656.262(2) outlines the employer reporting requirement as immediate and not later than five days. The section remains as written.

TESTIMONY: Section (2) of 54-100 should be deleted as it would cause misunderstanding by the employer resulting in failure to report claims. If retained, clarification of the term "medical services" is required.

RESPONSE: Many employers are providing their workers medical treatment beyond normal first aid and not reporting the injury as a workers' compensation claim. This section addresses the problem. The section is amended to reflect the concern of the testimony by including the definition of "medical services" as it applies to this section.

TESTIMONY: Section (5) of 54-100, the signed Form 827 should not relieve the worker or employer from completing a Form 801.

RESPONSE: This section requires the insurer to process a signed Form 827 as written notice of an accident the same as a Form 801 and does not relieve the worker or employer from filling out a Form 801. The section is reworded to reflect the concern and intent of the testimony.

TESTIMONY: Section (7)(a) and (b) of 54-100, the definitions "date of injury" and "occupational disease" create a possible statutory conflict and may be used outside this rule.

RESPONSE: The section is deleted in its entirety to avoid the situation expressed in the testimony.

TESTIMONY: Section (1) of 54-212 should be amended to include self-insured administrator in the last sentence.

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

TESTIMONY: Section (2) of 54-212 should be amended to allow: (1) mutual insurer prorate without approval; (2) adjustment between insurers; (3) offset of undue double payments; and (4) 10-day time limitation for Compliance Division to issue an order.

RESPONSE: This section insures uniform claims processing throughout the industry, as well as being consistent with the findings of the court in Jackson versus SAIF, 7 Or App 109, 490 P2d 507 (1971). A time constraint would not serve to expedite the process. The section remains as written.

TESTIMONY: Section (4) of 54-212, the terms "unscheduled" and "irregular" need to be defined.

RESPONSE: The terms "unscheduled" and "irregular" are identified under the subsections of this section. The section remains as written.

TESTIMONY: Section (4)(a) of 54-212, the last three words "employer and worker" should be changed to read "Compliance Division" as it is unlikely the employer and worker can agree what the intent was at the time of hire.

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

TESTIMONY: Section (4)(k) of 54-212, the language "when covered" should be inserted after the words "volunteer workers" so an apparent conflict with ORS 656.005(28) is not created.

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

TESTIMONY: Section (6) of 54-222, a new subsection should be added that allows no temporary partial disability due when the worker voluntarily and with mutual consent of the employer leaves offered employment temporarily or permanently for reasons unrelated to the injury.

RESPONSE: The recommended change is not in keeping with the intent of the law.

TESTIMONY: Section (3) of 54-232 should be amended to show the "commencement" of the program and not its authorization as when to suspend award payments and pay time loss.

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

TESTIMONY: Section (4) of 54-232 should be amended to reflect that temporary disability shall continue until an order by the Evaluation Division when no award remains due. The "award payments" should be clarified to refer to only permanent partial disability awards.

RESPONSE: The section is amended to reflect the concern and intent of the testimony regarding the payment of temporary disability and remains as written regarding permanent partial disability awards. Awards may include permanent total disability.

TESTIMONY: Section (1) of 54-245, the limiting word "only" should not be added as it serves no purpose and may keep a claimant from seeking reimbursement of paid medical services.

RESPONSE: The purpose of the amendment is to clarify that employers are not to pay a medical expenses directly and thus not report them to the insurer. The section remains as written.

TESTIMONY: Section (2) of 54-245, the definition should be limited to show automobiles do not qualify as a prosthetic appliance.

RESPONSE: To provide such a limitation is not appropriate. The section remains as written.

TESTIMONY: Section (4) of 54-245, the section should be deleted as a result of several Court of Appeals cases permitting the worker to choose an attending physician in any area within the state of Oregon and receive travel reimbursement. Further testimony would limit all travel reimbursement to the area where the worker resides at time of treatment.

RESPONSE: Appellate decisions have not challenged the adequacy of this rule, only its applicability to a given situation. The applicability of this rule must be considered separately in each case. The section remains as written.

TESTIMONY: Section (5) of 54-245 should be amended to require the worker to provide written notice to the insurer in advance of changing attending physicians outside the state of Oregon.

RESPONSE: The recommended change would prevent a physician who has treated a worker in good faith from being paid for services rendered. The current rule provides for this situation. The section remains as written.

TESTIMONY: Section (2) of 54-250 in combination with ORS 656.313 makes useless the employer's right to a hearing or appeal on the extent of disability by the fact the award must be paid in a lump sum without the right to reimbursement.

RESPONSE: This is a legislative requirement and cannot be changed by rule. The section remains as written. X

TESTIMONY: Section (3) of 54-250 should be eliminated as being unduly restrictive. The insurer should be able to advise the worker of the options available. There are adequate safeguards in effect during the approval process to adequately protect the worker.

RESPONSE: The section is deleted as recommended in the testimony.

TESTIMONY: Section (10) of 54-250, the five working days to make a lump sum payment is unreasonably short and should be changed to ten working days.

RESPONSE: The request for a lump sum payment is normally a result of the worker's immediate need for the money. To extend the time for making payment would cause an additional hardship on the worker. The section remains as written.

TESTIMONY: Section (13) of 54-250 should be amended to clarify that application for and approval of a lump sum payment of only part of an award waives the right to appeal the adequacy of the award.

RESPONSE: The concern reflected in the testimony is recognized and is relieved by amending the paragraph in subsection (5)(d) of this rule to read ". . . accepting a lump sum payment of all or any part of my permanent partial disability award,"

TESTIMONY: Section (2)(a) of 54-270 should be amended to add a reasonable time frame of within 180 days of expenditure for the worker to request reimbursement of related claim costs. The minimum amount reimbursable per trip should be \$2.

RESPONSE: A restriction of claim cost reimbursement to the worker should be by legislative law change and not by rule. The section remains as written.

TESTIMONY: Sections (2)(a) and (3) of 54-270 should be amended to allow 60 days to reimburse the worker for claim costs, as well as return requests for reimbursement of services not claim related. The change would provide consistency with the decision in Eubanks versus SAIF establishing 60 days to pay or deny medical services.

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

TESTIMONY: Section (2)(b) of 54-270, the proposed change to allow meals, lodging, and travel reimbursement to the worker to seek prescriptions is unreasonable and invites abuse. The new language should be eliminated or the rule should include reasonable restrictions.

RESPONSE: The new language is deleted as recommended in the testimony.

TESTIMONY: Rule 54-281, as well as, 54-283, 54-284, 54-285, and 54-286, do not provide the worker his "due process" when an insurer requests suspension of compensation as determined by the court in Carr versus SAIF.

RESPONSE: The rules are amended to provide the worker opportunity for due process to be in compliance with the decision in Carr versus SAIF, 65 Or App 110 (1983).

TESTIMONY: Section (7) of 54-281, as well as, sections (8) of 54-284, (11) of 54-285, and (14) of 54-286, should be amended so the worker has the burden of proof to prove the extent of disability. The language in each section should also be amended to read ". . . the Evaluation Division shall reduce . . ." rather than "may reduce."

RESPONSE: These rules are an extension of ORS 656.325, which provides that the employer or insurer may petition the director and ". . . the director may reduce any benefits . . ." Section (7) of 54-281 is amended to be consistent with the statute and the other three sections remain as written.

TESTIMONY: Section (1) of 54-283, the rule should be clarified for consistency with decisions of the presiding referee that the rule regarding three separate medical examinations only applies to "open" claims and not claims that are closed or in litigation.

RESPONSE: A request for suspension of compensation under this rule would apply to an open claim. Reference to a closed claim or a claim in litigation would, therefore, not be applicable under this section. The section remains as written.

TESTIMONY: Section (2)(d) of 54-283 should be eliminated since telling the claimant his physician was notified of the examination serves no purpose as the physician was already notified pursuant to an earlier rule.

RESPONSE: The notification in this section is to the worker and not the physician. The section provides notice to ensure the worker is aware of occurring events. The section remains as written.

TESTIMONY: Section (6) of 54-283, it is unclear why this section is being removed.

RESPONSE: The section is removed as unnecessary and inappropriate as a result of 54-284.

TESTIMONY: A new section to 54-283 should be added to provide for suspension of further medical treatment where no time loss is involved, and the worker fails or refuses to be examined.

RESPONSE: A new section is added to the rule to reflect the concern and intent of the testimony.

TESTIMONY: Rule 54-285 does not provide a definition of insanitary or injurious practices, thus creating the possibility of either unjust reduction or termination of the worker's benefits.

RESPONSE: An all inclusive definition of what constitutes an insanitary or injurious practice is impracticable. The concern is valid and is reflected by the fact both the attending physician and the medical director's opinions are sought. The rule provides appropriate safe-guard and remains as written.

TESTIMONY: Section (6) of 54-285 should be eliminated as it is unnecessary and creates an internal review process to which the parties have no access.

RESPONSE: Medical review and advise is necessary to relieve the concern reflected in the prior testimony. The section remains as written.

TESTIMONY: Section (11) of 54-285 should not be added to the rule. The section makes implication that the worker will do whatever necessary to maximize his disability.

RESPONSE: The section is a reflection of ORS 656.325 and provides no more implication of the worker's intent than 54-284(8) and 54-286(14). The section remains as written.

TESTIMONY: Section (5)(c), (6) & (8) of 54-286, the term "reasonable" should replace the terms "essential" and "reasonably essential" to be consistent with statutory and case law.

RESPONSE: The language throughout 54-286 is amended to read "reasonably essential" to be consistent with the language in ORS 656.325(2).

TESTIMONY: Section (6) of 54-286, the new language "the physician recommending such treatment" raises concern the consultant physician will be in control of the patient's case.

RESPONSE: The section is being amended for the reason the medical or surgical treatment necessary may be out of the expertise of the attending physician and cannot be adequately explained to the worker. The attending physician by section (5)(c) still has the opportunity to state whether the treatment is reasonably essential to promote the worker's recovery. The section remains as written.

TESTIMONY: Section (1) of 54-305 should require acceptance within 60 days after the employer has had written notice or knowledge of the claim in order to be consistent with ORS 656.265.

RESPONSE: The section remains as written to be consistent with the language of ORS 656.262(6).

TESTIMONY: Section (1) of 54-305, the 60 days is too long -- only 30 days should be allowed to accept or deny a claim.

RESPONSE: The time period is statutory and cannot be changed by the rule.

TESTIMONY: Section (2) of 54-305, the proposed new language "'reported' claims" should be deleted and the old language continued.

RESPONSE: The "total volume of claims" figure is not available to the department, therefore, monitoring of claims per this rule cannot occur. The change is necessary and should not affect the overall performance of the insurer as the volume of reported claims should represent an adequate sample of the insurer's or self-insured employer's performance. The section remains as proposed.

TESTIMONY: Section (5) of 54-305, a considerable amount of material was presented concerning this rule as it relates to the effects of Oregon Law 1983, Chapter 809 (SB471), and the extent of the rules applicable thereto. Major points presented were:

- The burden of notifying the health provider should be that of the worker as knowledge of all health providers is not readily available to the insurer. The insurer should only have to notify those health providers known.
- The department, under its authority, needs to interpret SB471 and provide policy and procedure to make it workable.
- There may be a question as to whether the Workers' Compensation Board or Workers' Compensation Department ought to be the proper authority to enact rules in regard to SB471.
- A dispute exists as to whether SB471 was intended to apply to noncompensable claims as well as compensable claims.
- A dispute exists as to whether or not arbitration should be resolved under the workers' compensation system.
- A questions exists as to what workers' compensation matters should be arbitrated.
- Disputed claim settlements do not resolve the issue of compensability and leave the health providers at some risk for the medical and hospital bills.
- No interpretive regulations are required as the intent of SB 471 is sufficiently clear.

RESPONSE: In reviewing the testimony relating to SB 471, the department finds the concerns and problems expressed relating to SB 471 are speculative and not supported by actual experience. At the same time, the question of authority and jurisdiction remains unclear. Accordingly, rule 54-305(5) remains as proposed. If a need for rules on the subject is identified after experience with the statute and the department has authority, the rules will be opened for public hearing to meet the need.

TESTIMONY: Section (3)(a) of 54-310, the employer's notice should be receipt of written notice and the term "immediate and payable" should be replaced by the word "due."

RESPONSE: The language of the rule is consistent with the statute. The section remains as written.

TESTIMONY: Section (3)(f) of 54-310, the term "referred" is not sufficient to require the institution of temporary disability without actual knowledge that time loss is involved.

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RESPONSE: The referral only applies to a starting point for determining timely payment of temporary total disability. Actual payment of compensation would be no different than any other subsection of this section. The section remains as written.

TESTIMONY: Section (7) of 54-310, the requirement of a formal notice to the worker adds a costly and time consuming procedure to an already costly system. The proposed new section should be deleted.

RESPONSE: The proposed section is deleted to reflect the concern of the testimony.

TESTIMONY: Section (8) of 54-310, medical providers feel the time period for timely payment should be reduced from 45 days to 30 days to relieve their cash flow costs. The insurance industry feels the time period should be increased to 60 days as a result of Eubanks versus SAIF case.

RESPONSE: The section is amended to reflect the findings in Eubanks versus SAIF.

TESTIMONY: The first paragraph of 54-320 should be amended so the last sentence reflects "temporary total disability benefits" and a new sentence added that allows recovery of disability benefits paid pending appeal.

RESPONSE: The rule is consistent with the statute and remains as written.

TESTIMONY: Section (4) of 54-332, the rule needs stronger language regarding reciprocal discovery to avoid one-sided action on the part of the parties involved.

RESPONSE: The current rule is sufficient in that 54-981 allows for a penalty to be assessed where an insurer fails to process a claim in accordance with this rule. The section remains as written.

TESTIMONY: Section (4) of 54-332, a new sentence should be added requiring that a claim for aggravation must be supported by a medical report relating the condition to the original injury. This requirement would eliminate frivolous filings.

RESPONSE: An amendment as proposed would restrict the purpose of the rule. The section remains as written.

TESTIMONY: Section (6) of 54-332 is unnecessary since a penalty section already exists in 54-981(2).

RESPONSE: The section is deleted to reflect the concern of the testimony.

TESTIMONY: Section (12) of 54-332 should be eliminated since a .307 Order can only be entered when the issue of responsibility is the only issue. Questions under ORS 656.029 are jurisdictional in nature and must be resolved before either compensability or responsibility can be decided.

RESPONSE: The question of compensability can be decided separate from the question of jurisdictional or responsibility. If all parties agree the claim is otherwise compensable, a .307 Order can be issued. The section remains as written.

TESTIMONY: Section (14) of 54-332 should be amended to add that partial or aggravation denials of responsibility for isolated noncompensable conditions are allowed.

RESPONSE: The presence of a .307 Order does not prevent normal claims processing activity. The recommended clarification is not necessary. The section remains as written.

TESTIMONY: Section (15) of 54-332, a new section should be added for clarifying that Own Motion claims are exempt from the provisions of these rules.

RESPONSE: A new section is added to reflect the concern and intent of the testimony.

TESTIMONY: Section (1) of 54-334 should include the language "prior to the receipt of the order" as there is a time lag between the date of the referee's order and receipt of the order by the insurer. The insurer should be able to recover money from the administrative fund due to this lag time.

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

TESTIMONY: Section (1) of 54-334 should be amended to allow reimbursement to insurers who voluntarily continue payment of disability to the worker pending designation of a paying agent where the other insurer has delayed their decision to accept the claim and caused a situation where no .307 Order could be issued. The difference of disability rates if not recovered should be reimbursed from the administrative fund.

RESPONSE: Situations as described should not occur as interim compensation is required paid pending acceptance or denial of a claim. The proposed amendment is not necessary.

The staff recommended changes which clarified the rules and made them more readable. Those changes have been incorporated into the rules.

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

DATED THIS 29 DAY OF DECEMBER, 1983.

Workers' Compensation Department



Fred Segrest, Deputy Director
Presiding Officer